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ABSTRACT

Presented are the findings of a study conducted to evaluate two community protective service systems in terms of the mechanisms for identifying and handling child abuse and neglect cases and the effectiveness of intervention. It is noted that data was collected in two sites: Site I (Nashville, Tennessee), which has an emergency reporting system and a 24-hour protective service program; and Site II (Savannah, Georgia), which has a more traditional protective service system with no internal provision for 24-hour intake within the public welfare system. The first three chapters cover an introduction to protective services, the definition and major elements of service systems, and methodology of the study (including background of the research project, general objectives, research design, evaluation criteria, and limitations). Two chapters report on the findings regarding each site in terms of its relationship to collateral systems, systems operations, and observed problems. Provided in a final chapter are a discussion of the similarities and differences between the two systems in terms of system structure, a comparative evaluation of the systems' functions, a summary of major insights, and a presentation of recommendations (such as that intake into the mandated protective service system be provided on a 24-hour basis). (SB)

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TWO COMMUNITY PROTECTIVE SERVICE SYSTEMS: COMPARATIVE EVALUATION OF SYSTEMS OPERATIONS

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March, 1976.

PREFACE

The general purpose of this study was to evaluate two community protective service systems in terms of the mechanisms for the identification and the handling of child abuse and neglect cases and the effectiveness of intervention.

Data were collected in two sites. Site I, which has an emergency reporting system and a comprehensive 24-hour protective service program, is Nashville, Davidson County, Tennessee. In Site II, Savannah, Chatham County, Georgia, the protective service system is a more traditional one with no internal provision for 24-hour intake within the public welfare system.

This monograph reports the findings relevant to the systems' structure and case handling processes. A subsequent report will focus on the nature and effectiveness of intervention.

TABLE OF CONTENTS

Acknowledgements ii
Preface iii

CHAPTER 1: INTRODUCTION 1

Background Statement 1
The Nature of Protective Services 1
Charges Against Social Service Delivery 4

CHAPTER 2: CONCEPTUAL FRAMEWORK 7

Definition and Nature of Systems 7
Major Elements in Analysis of Service Systems 8
Integrating Statement 8

CHAPTER 3: METHODOLOGY OF THE STUDY 11

Background of the Research Project 11
General Objectives 11
Research Design -- Evaluation Research Utilizing the Exploratory Descriptive Design 11
Evaluation Criteria 12

Evaluation of Systems Operations 12
Evaluation of Effectiveness 13

Protective Service Delivery Systems Studied 14
Data Sources and Research Procedures 14
Focus of this Report 15
Major Considerations 15
Limitations of the Study 16

CHAPTER 4: CES -- NASHVILLE, DAVIDSON COUNTY, TENNESSEE 17

Relationship of CES to Collateral Systems 17

CES and Health Systems 17
CES and Law Enforcers 18
CES and the Juvenile Court 19

CES Systems Operations 19

CES Service Components 20
The Intake Process 20
Screening and Investigative Processes 21
Case Assignment and Handling 22
Record Keeping 22

Some Observed Problems 22

Problems in Case Transferral 22
Problems in the Intervention Process 23
Problems in the Delivery of Services 24

Summary Statement 24

CHAPTER 5: PROTECTIVE SERVICE UNIT – SAVANNAH, CHATHAM COUNTY, GEORGIA 25

Relationship of PSU to Collateral Systems 25

PSU and Health Systems 25
PSU and Law Enforcers 26
PSU and the Juvenile Court 27

PSU – Systems Operations 27

The Intake Process 27
Screening and Investigative Processes 28
Case Assignment and Handling 28
Record Keeping 29

Some Observed Problems 29
Summary Statement 31

CHAPTER 6: COMPARATIVE SUMMARY OF SERVICE FLOW 33

System Structure 33
Comparative Evaluation of the Systems' Functions 38

1. Coordinating and cooperating with the environment 38
2. Intake 41
3. Screening 42
4. Investigation 42
5. Case Assignment 44
6. Case Handling 44

A Summing Up of the Systems' Operations 45
Recommendations 46
Summary Statement 49

BIBLIOGRAPHY 51

Chapter 1

INTRODUCTION

Background Statement

Historically, children have been subordinate beings in most known societies with parents or other caretakers virtually possessing the absolute power of life and death over them. And all too often, throughout time, the exercise of adult powers over children has resulted in extreme maltreatment of children and even death.[1] In America up until 1874, few, if any, laws or societal mechanisms existed which were designed to regulate care and protection of children.

In fact, societies for the prevention of cruelty to animals -- 1822 in England and 1866 in America – were organized before those for the protection of children. The first action taken in the interest of child protection was initiated through the New York Society for the Prevention of Cruelty to Animals. The impetus for the action was the discovery, by a church worker, of a child who was being extremely maltreated by her step-mother and father. The church worker, finding deaf ears from legal and authoritative sources to her pleas for help for the child, approached the S.P.C.A. with her concerns. The actions of the society resulted in the removal of the child and jail terms for her parents. Subsequent to the "Mary Ellen" case the New York State Legislature, in response to public opinions, passed laws protecting children's rights and authorized the creation of societies for the prevention of cruelty to children. In 1875, the first such organization anywhere, the New York Society for the Prevention of Cruelty to Children, was formed.[2]

Concern for children gained impetus as similar organizations in other communities followed the creation of the New York S.P.C.C. Additional support for the cause of children subsequently followed through the federal government. Child welfare programs were the earliest social welfare service programs provided by the federal government. But even with the advent of private agencies and the eventual creation of the Children's Bureau in 1912, the "collective" conscience of the American society was not actively raised to the level of concerted ongoing intervention on behalf of children's welfare. Only within recent years has society defined child abuse and neglect as a social problem.

It was in the early 1960's that the public was shocked by publicized accounts of physical abuse to children. In response to the social situation, the Children's Bureau in 1963 published *The Abused Child – Principles and Suggested Language for Legislation on Reporting of the Physically Abused Child* as a basis on which states could model their reporting laws.

By 1967 all of the states had passed child abuse legislation. Many states have since amended their laws and others have repealed them. While states vary with respect to the inclusion and prescriptions of elements in their statutes, most states place the responsibility for case handling in the department of public welfare.[3]

How well the intended goals of the laws can be effectuated depends, in part, on the nature and extent of the problem and the system's mechanisms designed to deal with the problem. What are protective services? What are the mandates guiding the delivery of protective services? How well does delivery of services approximate the mandates? These issues will be addressed briefly in the following section.

The Nature of Protective Services

Protective service programs are designed to protect children who are at risk of or are actually the victims of physical abuse, neglect, sexual molestation, and other forms of maltreatment. The extent to which children are abused and neglected is not known; for despite the existence of reporting statutes, many cases are simply not reported even by mandated reporters. Yet, recent years have witnessed a phenomenal increase in reported cases of abuse and neglect. Approximately 9,000 cases of physical abuse were reported in 1967. Present annual

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[1] For an historical account of maltreatment to children see Lloyd De Mause, "Our Forebears Made Childhood a Nightmare," *Psychology Today* (April, 1975) pp. 85-88. Mary Van Stolk, *The Battered Child in Canada* (Toronto: McClelland and Stewart Ltd., 1972), Chapter 16.

[2] See Emma O. Lundberg, *Unto the Least of These* (New York: Appleton-Century-Crofts, Inc., 1947), pp. 102-105.

[3] For a comparison of states' legislation see Vincent De Francis, *Child Abuse Legislation in the 1970's* (Denver, Colorado: The American Humane Association, Children's Division, 1970).

estimates range from lows of 25,000 to 500,000 to a high of between 2.5 and 4 million.[4] Low estimates generally represent physical abuse only. Estimates of neglect are usually 3 to 4 times higher than those for physical abuse, and sexual incidence is estimated to be approximately twice as high.

Whatever the actual incidence may be, if cases are not reported, the system for protection and care will probably not be brought to bear. Reporting sets in motion the states' machinery for protecting children and helping their families. Child protective services differ from the usual social services rendered in the following ways:

1. Child protective services are involuntary; they are initiated by public welfare agencies rather than ensuing from a relationship initiated by the client. The initial intervention in many communities is undertaken by law enforcement agencies.

2. Protective service agencies carry the right to use authority. Social agencies may invoke the powers of the court for the child's protection.

3. Protective service agencies carry a higher degree of responsibility than do voluntary service agencies. In rendering protective services the agency is, in effect, carrying out its obligation to the community in guaranteeing the rights of children.

As guidance for the delivery of protective services, the Children's Bureau proposed that a state or local welfare agency be required to:

> Investigate complaints of neglect, abuse, or abandonment of children and youth by parents....or persons serving in loco parentis; and on the basis of the findings of such investigation, offer social services to such parents....or persons serving in loco parentis in relation to the problem, or bring the situation to the attention of law enforcement agency, an appropriate court, or another community agency.[5]

The intent of the above mandate has been included in the "Child Abuse Prevention and Treatment Act":

> ....[P]rovide that upon receipt of a report of known or suspected instances of child abuse or neglect an investigation should be initiated promptly to substantiate the accuracy of the report and, upon a finding of abuse or neglect, immediate steps shall be taken to protect the health and welfare of the abused or neglected child, as well as that of any other child under the same care who may be in danger of abuse or neglect.[6]

The proposed regulations for the Act suggest multidisciplined/multi-service resourced channels to deal with the problems of child abuse and neglect "....in order to protect the child and help strengthen the family, help the parents in their child rearing responsibilities, and if necessary, remove the child from a dangerous situation."[7]

The above passages indicate that a prompt investigation of the complaint is the initial requirement in the sequence of protective services. This need is especially crucial since one of the apparent criteria for a determination of the existence of abuse is that of visible effects.

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[4]See the following sources for estimates by type of abuse. Saad Z. Nagi, "Child Abuse and Neglect Programs: A National Overview," *Children Today* (May-June, 1975) pp. 13-17. Stephan J. Cohen and Alan Sussman, "The Incidence of Child Abuse in the United States," *Child Welfare* Extended Issue Vol. LIV, No. 6, (June, 1975) pp. 432-442. Richard J. Light, "Abused and Neglected Children in America: A Study of Alternatives," *Harvard Educational Review*, Vol. 43, No. 4 (November, 1973) pp. 556-598. Vincent De Francis, "Protecting the Abused Child – A Coordinated Approach," *A National Symposium on Child Abuse* (Denver, Colorado: The American Humane Association, Children's Division, 1972) p. 8.

[5]U.S. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau: *Proposals for Drafting Principles and Suggested Language for Legislation on Public Child Welfare and Youth Services*, 1957 (Multilithed).

[6]Public Law 93-247, 93rd Congress, 5.1191 (January 31, 1974).

[7]Department of Health, Education, and Welfare, Office of Child Development. Proposed Rules for the Child Abuse Prevention and Treatment Program, *Federal Register*, Vol. 39, No. 168 (August 28, 1974), section 1340.3-3(3)(ii).

Far too often, however, the time which elapses between time of incident, time of report, and time of official investigation is sufficiently long enough to allow the visible qualities of physical abuse and some neglectful conditions to disappear.[8]

Beyond the matter of time and observable injuries and/or neglectful conditions is the question of the investigation itself. What criteria should be used to determine whether or not abuse has been perpetrated or neglect exists? Should the focus of the investigation be on the child's condition? On parents, especially mother's psychological state? Parents' interactional patterns? Socioeconomic factors and immediate family circumstances? All of the above and/or some combination of the above in conjunction with other factors? We cannot attest to the commonality of the practice nationwide, but we found that investigators of reported child abuse cases in Region IV did not use any form of objective guide; the focus depended on the investigators' personal orientation. Objective guides would appear to be a vital, though neglected, aspect of the total investigative process in handling child abuse and neglect cases.[9] For, indeed, it seems logical to assume that the decisions on the appropriateness of services to the child and its family should rest on an adequate assessment of the total situation. Services offered should reflect an understanding of existing family problems and living conditions, the recognized precipitating factors(s), as well as the nature and extent of the abuse or neglect.

Protective service units have a wide range of protective services, as well as court ordered protective supervision, from which to draw in working with abused children and their families. In the main, two basic groups of services are normally available: (1) services to children requiring placement outside the home, and (2) services to children in their own home. What appears to be lacking, however, are criteria for making judgments concerning the appropriateness of given services and at what point.[10] Another service delivery problem involves decisions pivoted around referrals. When should referrals be made and to what community resources?

The confusion in the offering of services was noted by Terr and Watson. They studied 10 battered children and their families who received an assortment of medical, legal, and social work handling over a period of two years. They found that as a result of confusion, delays, poorly coordinated efforts, and failures by agencies and individuals to assume responsibility for appropriate action, serious emotional stresses were produced in the children who were already traumatized youngsters.[11]

A pilot study undertaken at a Los Angeles Children's Hospital showed that traditional approaches to child protective services have been a failure to both children and their parents. It was found that four out of every five children were placed in foster homes and remained for long periods of time. It was felt that the foster home system affected children negatively and insufficient efforts were made to change parents during the children's placement.[12]

Indeed, there are many problems involved in the delivery of social services in general and protective services in particular, especially in relation to legal issues, decisions on treatment modalities, and modes of intervention on behalf of children, e.g., placement. While the de-

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[8] It was revealed in a Regional Study of Child Abuse that, in the cases for which time between the reported incident and official assistance was known, in 39.6% of such cases at least three days lapsed. Johnson, *Child Abuse in the Southeast: Analysis of 1172 Cases*. Research Monograph, Regional Institute of Social Welfare Research, University of Georgia, 1975, p. 153.

[9] Bell and Mlynicc present a suggested guide for the identification of child abuse and neglect. See, Cynthia Bell and Wallace J. Mlynicc, "Preparing for a Neglect Proceeding: A Guide for the Social Worker." *Public Welfare* (Fall, 1974), pp. 26-37.

[10] Robert M. Mulford, "The Role and Function of Protective Services." *A National Symposium on Child Abuse* (Denver, Colorado: The American Humane Association, Children's Division, 1972), pp. 42-49.

[11] Lenore C. Terr and Andrew S. Watson, "The Battered Child Rehabilitated: 10 Cases of Medical-Legal Confusion." *American Journal of Psychiatry*, Vol. 124, No. 10 (1968), pp. 1432-1439.

[12] The Hospital has been funded to conduct a 4 and ½ year study to demonstrate the ineffectiveness of present protective service system, including court intervention, and to propose alternative approaches. "California Child Abuse Study Indicates Insufficient Effort to Change the Parents," *New York Times* (January 3, 1974).

livery of services cannot be problem free, the criticisms concerning quality and effectiveness of services continue to mount.

Charges Against Social Service Delivery

Criticisms of the ineffectiveness of social work in general and social programs in particular have placed public welfare services and programs on the firing line from many fronts. While social work as a profession and public welfare programs have a young history in America, social work activities are expected and have been presented by service providers as "all things to all men." Indeed, social work has set for itself a most difficult task, that of rendering services designed to influence the social functioning of man and thus bring about change. In this major task, critics warn that positive effects have been negligible; the public dollar could be better spent.

It appears that present welfare programs and the delivery of services under the programs are being attacked by virtually everyone. Recipients of public welfare services, themselves, are a major critical force which is increasingly evident in the growth and activities of welfare rights groups. Tax payers are appalled at the federal, state, and local monies which they feel are being poured into activities and programs having little or no impact on the conditions of the people they are designed to help. And professionals working in and around welfare programs at the levels of direct service, policy making, and research are themselves becoming critical of some programs and their management.

One may be most aware of criticisms against social welfare programs when one recalls the operations and outcomes of programs initiated under the Economic Opportunity Act which is identified with America's commitment to its poor. The legislation was heralded as a "total war on poverty" with the dual aim of eliminating poverty and restructuring society by giving the poor a chance to participate in the designing and administering of antipoverty programs.

While more people received more services than ever before, the reality of the matter is that neither goal was realized. Beyond such charges as lack of funds, top heavy administration, and failure to plan effectively, a significant charge against the programs was the lack of coordination and unclear roles between governmental levels.[13]

Realizing the complexity of a service delivery system, Rosenberg and Brody suggest that coordination and integration are necessary to bring programs "....into a manageable and coherent social service system that is responsive to consumer needs."[14]

There are many negative consequences of fragmented services to the consumers and to the agencies and/or other components responsible for service delivery.[15] It cannot be overemphasized, that if the recipients of a system's services are not receiving services appropriate to their needs, then the system fails in its avowed mission. Beyond this failure caused, in part, by fragmented services, agencies, for the same reason, fail themselves Uncoordinated or fragmented systems do not readily lend themselves to documentation of services rendered and the impact of those services. On these two conditions rests an agency's basis for seeking additional needed funds.

Indeed, accountability and evaluation are increasingly current pressing concerns. The tone of these concerns in relation to children was noted in a speech by Senator Mondale in which he made the following observations:

> During Senate hearings and investigations on large-scale social problems of hunger, education, health, poverty, and migratory labor, several points have become clear. First, as difficult as these problems are for all of the people they affect, they almost always hit children the hardest....A second, almost equally disturbing realization is that while we have made significant new investments in education, health care, and nutrition programs for poor children, our

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[13] Sar A. Levitan, *The Great Society's Poor Law: A New Approach to Poverty* (Baltimore: The John Hopkins Press, 1969).

[14] Marvin Rosenberg and Ralph Brody, *Systems Serving People: A Breakthrough in Service Delivery* (Clevelard, Ohio: Case Western Reserve University, School of Applied Social Sciences, 1974), p. 1.

[15] For a discussion of consequences of fragmented services, see Marvin Rosenberg and Ralph Brody, pp. 1-3.

ability to evaluate them has often been disappointing. Our studies have tended to concentrate on the "cold" facts of input variables, like amounts of money spent on schools or numbers of child care slots available, and too often have been unable to measure the "hot" facts or output variables like how, or to what degree, or with what performance children are actually benefiting from programs designed to help them. We are making progress, but we still do not know enough about how federal and state programs for the disadvantaged are assisting children to be healthier and better motivated, or to learn to read, spell, and do basic math.[16]

An empirical study which serves as an indictment against the delivery of social services by public welfare agencies, *Social Services: Do They Help Welfare Recipients Achieve Self-Support or Reduced Dependency?*, by the General Accounting Office, addressed the following questions.

1. Do developmental social services increase the likelihood that recipients will become self-supporting and leave the rolls?

2. Do developmental social services reduce dependency by increasing the amount of earned income while on assistance?

3. Do agencies have the capacity to direct services to families most likely to reduce dependency or leave the rolls?

The researchers found no evidence of service impact, i.e., services were viewed as unproductive. One major suggestion of the study was that improvements in management of services are not only essential, but possible.[17]

While the study's methodology, conclusions, and recommendations have been criticized, there is little doubt that the findings will influence Congress and the future of welfare programs.[18]

If public social service systems can be criticized for ineffective delivery of services, there can be little doubt that the systems designed for the protection of children (primarily involuntary in nature and ladened with ambiguous legal implications for children, their parents, and agencies) will eventually receive their share of criticism. It would appear that one means of anticipating frontal attacks would be to evaluate where communities are with respect to the problem, mechanisms for handling the problem, and an evaluation of the effectiveness with which problems are dealt.

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[16]"A Statement by Senator Walter F. Mondale," *Harvard Education Review*, Vol. 43, No. 4 (November, 1973) p. 483.

[17]U.S., Comptroller General, *Social Services: Do They Help Welfare Recipients Achieve Self-Support or Reduced Dependency?* (Washington, D.C.: General Accounting Office, June 27, 1973).

[18]For a critical analysis of the research, see Michael Wiseman and Gerald Silverman, "Evaluating Social Services; Did the General Accounting Office Help?", *Social Service Review*, Vol. 49, No. 3 (September, 1975) pp. 315-326.

Chapter 2

CONCEPTUAL FRAMEWORK

Considering the various facets of child abuse and neglect and the various agencies which may become involved from the point of detection through the resolution of the problem, a knowledge of a community's mechanisms for handling such cases from a system's perspective appears to be essential. More specifically, the nature and extent of cases identified and reported and by what agencies, the available resources which can be brought to bear, the status and knowledge of intra and interagency coordination and cooperation, the existence and nature of problems encountered by each of the agencies because of the ways other agencies handle abuse and neglect cases, and the nature and outcome of services rendered, all constitute important indicators of a system's performance.

The use of the systems model is an appropriate framework for examining a community's approach to the delivery of protective services. While there are varied usages of the "system" concept, e.g., computer system, telephone system, social system, etc., the terms "systems concept" and "systems approach" are ways of viewing any organization of physical or human components. As such, the systems model can be viewed as an analytical tool for investigating the functioning of interrelated parts which are crucial to the phenomenon being studied.

Systems analysis aims at discovering how a total system functions by virtue of the interdependence of its parts. It provides a direction for viewing phenomena; as such, it can provide a schema for bringing order out of chaos and specifying previously unidentified relationships. Moreover, it suggests ways of making new observations over a wide range of phenomena in order to extend the understanding of basic underlying principles.

Definition and Nature of Systems

A system is composed of a series of interrelated parts whose activities are coordinated according to a set of predefined rules and procedures. At the same time, an identified system includes subsystems and is part of a suprasystem. Any analysis must, therefore, both define the particular system under study, and recognize that the system is simply a part of a whole complex of subsystems, systems, and suprasystems.

Considering this aspect of systems, it isn't always an easy task to clearly delineate the parameters for study, i.e., system's boundaries. Matthews indicates that:

> The systems view can be expanded to the examination of any operation to include all other operations which influence the behavior of the operation under study. As all operations have some impact on other operations, which have impact on other operations, and so on, this view could cause the examination of any operation to include the entire universe. Obviously this is impractical. From a practical point of view, what the system concept does imply is consideration of the organization in as broad a context as possible. The optimization of an individual operation or department will not necessarily optimize the total organization. There are, however, points where the potential impact of the interaction will diminish below the threshold values of the impact of additional investigation. These tradeoff considerations will define practical boundaries for the system. When these system boundaries have been established, the system concept requires that the chain effects of the relationships within these boundaries be considered.[1]

We can view the system, then, in a dynamic sense as a network of channels within specified or predetermined boundaries through which products, services, resources, and information flow within the system and between the system and its environment.

The system concept involves both an internal and external environment. The interaction of the systems components control and alter the internal environment. The external environment, which is not a part of and is, therefore, beyond the direct control of the system, consists of forces which act on and influence the system's

[1] Don Q. Matthews, *The Design of the Management Information System* (New York: Auerbach Publishers, 1971) pp. 16-17.

functioning.

Major Elements in Analysis of Service Systems

The analysis of a system involves examining input, operations or conversion processes, i.e., the coordinated action and activities of the various parts which control and are controlled by the internal environment, and system output.

Inputs are generally viewed as resources and client input. Resource input, i.e., staff, funds, and available services are active inputs which are used by the system to process clients. Client inputs are used by the system or acted upon in order for the system to realize its major service goals.

Input also includes feedback or information flow. Feedback can be defined as "....a signal from the operating system about its functioning and relationship with its environment."[2] Such input, if used, allows the system to determine and correct malfunctions in its own operations and to seek needed changes in the environment.

There is a great value in input information. Such information helps in the monitoring of the characteristics of successive groups entering the system and the determining of changes which might require adjustments in the service delivery process. Moreover, this kind of information helps administrators set realistic goals for the system.

Given inputs, i.e., resources, clientele, as well as restrictions, e.g., in the form of limitations of public opinion, morale, attitudes, and administrative constraints, a social service system can be viewed as a process which transforms input elements into (hopefully) desirable products. Systems operations or the conversion process refers to the total process of assessing and serving clients; this includes negotiations with internal and external environments toward the end of goal realization.

This kind of descriptive information, when compared to other systems, would permit the administrator to view his particular set of operations in the context of other systems with similar objectives. Gaps in the system can be identified where certain recommendations for innovative practices can be tried out.

System outputs refer to activities of and services rendered by the system. Outputs are distinguishable from outcomes which refer to the impact of the services on the process of clients who have passed through the system, i.e., as they relate to previously specified objectives -- reflect changes in the problem or need status. While output information allows a system to view and assess its activities in terms of its objectives, it is outcome information which allows the system to evaluate the effectiveness of the activities and services.

The relationship of the elements in a social systems analysis is described by Rosenberg and Brody who indicate that a "....system takes in inputs across this boundary (input process), engages in a conversion process by transforming these inputs and then exports the products of the system as outputs across the boundary."[3]

Integrating Statement

In the remaining of this report, attempts have been made to gain insight into the protective service delivery system in two communities. The primary goal has been to determine and describe the internal functioning of the protective service units and their relationship to the parent agency, i.e., the public welfare agency. Beyond these considerations, we have attempted to determine the relationship between the protective service system and the external environment, i.e., major collateral systems, to gain insight into the community network for handling child abuse and neglect cases.

While the larger study provides data germane to the major elements of the systems model, i.e., input-operations-output, this report deals with the system's operations only. One important factor demanded our taking this approach. Beyond the fact that input and output data are presently being analyzed, we felt the need to devote considerable attention to the structuring and operations of two distinctly different systems. Guides are sorely needed for developing protective service delivery systems. Thus, a close scrutiny of the functioning of these systems and a discussion of the insights gained might well serve as some of the guides needed. A subsequent report will integrate findings and insights incor-

[2] Rosenberg and Brody, p. 13.

[3] *Ibid*, p. 12.

porated in this report with input and output data.

A final point must be made. While the systems model has served as the conceptual framework for the total study, we have consciously tried not to become bogged down in a play of strict technical jargon. Rather, our approach has been simply to utilize the tool as a framework for data collection and analysis and a comprehensible format for presenting the results. We propose not to add nor detract from the development of systems analysis as a methodological procedure.

Chapter 3

METHODOLOGY OF THE STUDY

Background of the Research Project

This project, which was officially launched in the fall of 1973 with data collection beginning in the spring of 1974, was aimed at exploring certain issues relevant to the mechanisms for and the effectiveness of social intervention in child abuse and neglect cases. This is a crucial issue in view of present social awareness of and concern about the nature, incidence and causation(s) of abuse and neglect, and the services delivered in such identified situations.

The project emanated from some of the concerns emerging out of our Regional study of child abuse and neglect, the results of which have been analyzed, reported, and distributed nationally in two research monographs.[1]

General Objectives

The following objectives guided the research process:

1. To determine, at the local level, the organization and structure of protective service delivery systems.

2. To determine and assess the nature and content of services delivered.

3. To determine the effectiveness of the protective service delivery systems.

4. To develop models for training and service delivery systems based on the findings.

Research Design – Evaluation Research Utilizing the Exploratory Descriptive Design

Evaluation research involves the collection of information for the purpose of assessing the outcome or impact of a program or a system's functioning. While there are many possible uses of evaluation information, one of the fundamental purposes of evaluation is to produce information, i.e., feedback, which can be utilized in decision making. The need for evaluation as a decision making tool rests on two fundamental conditions, i.e., some recognized objectives or set of objectives and alternative means for realizing the objectives.

Ideally, an evaluation study involves the collection and analysis of data regarding the major elements of a system, i.e., inputs, operations, and outputs. Given constraints imposed by limited manpower, the nature of the system, time and amount of funds available for research efforts, the ideal in evaluation research isn't always obtained.

According to Astin and Panos, there are five evaluation methods: 1) description of operations which is the least complex and perhaps the most widely used; 2) measurement of outputs; 3) measurement of operations and outputs; 4) measurement of inputs and outputs; and 5) an analysis of input, operations, and output data. Undoubtedly, decisions based on the latter method would have more empirical support than those ensuing from findings in the other methods.[2]

This study has not been evaluative in the sense of attempting to determine causal relationships between the system components within each system studied; rather, one system is being compared to the other with respect to the components. According to Astin and Panos, this design, i.e., comparing two systems on one component is a legitimate undertaking. However, by focusing upon all the components within each system, it is possible to form hypotheses regarding relationships between components and differences, if any, observed between the systems with respect to system impact. A wholly generalizable design would involve randomization of cases in each system in order to account for the effect of vari-

[1] Clara L. Johnson, *Child Abuse: State Legislation and Programs in the Southeast.* (August, 1973) and *Child Abuse in the Southeast: Analysis of 1172 Cases.* (Fall, 1974). Research Monographs, Regional Institute of Social Welfare Research, University of Georgia.

[2] Alexander W. Astin and Robert J. Panos, "The Evaluation of Educational Programs," *Educational Measurement* 2nd edition, edited by Robert L. Thorndike (Washington, D.C.: American Council on Education, 1971), pp. 733-751.

ables not considered as part of the study.

The explanatory-descriptive design has been selected due to the nature of the research, i.e., identification of the issues and constraints affecting service to consumers. The major emphasis in the exploratory study is on the discovery of ideas and insights. This means, therefore, that the research design must be flexible enough to allow for the consideration of various aspects of the phenomenon under study. Descriptive information does not involve any explicit statements of causal relationships. The description may be entirely qualitative or it may also involve quantitative features.

Evaluation Criteria

As previously indicated, the general purpose of this study has been to evaluate two protective service systems in terms of the mechanisms for the identification and the handling of child abuse and neglect cases and the effectiveness of intervention.

With respect to this goal, we have conceptualized criteria presumed to be basic both to the realization of a protective service system's functions or activities and to a determination of the effectiveness of services rendered by the system.[3] Outlined below are the major activities, evaluation criteria, and factors considered to be contributory toward the way the systems functioned. The above elements are basic to the present report and will be considered in the comparison of the two systems' operations in Chapter 6. Secondly, criteria which will be utilized to evaluate the effectiveness of intervention which will be a major thrust of a forthcoming report, have been included.

Evaluation of Systems Operations

Functions/Activities. A system's functions or activities are, in effect, the components through which the system operates. The major functions of a protective service system, as we view them are:

1. *Coordination and Cooperation with the Environment.* The protection of children is a community affair, one in which many systems may and must become involved if the protective service program is to be a success. Viewing the protection of children in this manner, it logically becomes an expected function of the system, mandated to protect abused and neglected children, to initiate and/or maintain a well coordinated and cooperative relationship with its environment.

2. *Intake.* Entrance into the protective service system occurs through intake. The intake function involves the screening of cases to determine the nature of the action to be taken.

3. *Screening.* While screening can and is generally considered an aspect of the intake process, we have chosen to treat screening as a separate function or activity, as each system handled the process in distinctly different ways.

4. *Investigation.* The investigation, through which the validity of complaints is determined, has probably always been a major activity of protective service systems. However, in view of the mandate in Public Law 93-247, requiring that the State provides for an investigation of every reported known or suspected instance of abuse or neglect, we can assume that the investigatory function will become increasingly more important as a protective service system activity.

5. *Case Assignment.* Case assignment as a function may be related both to investigation and to case handling. In relation to the investigatory function, the assignment of cases appears to be based on assumptions regarding the nature of the incident and the severity of the injuries or the neglectful conditions. The assignment of cases for "management" purposes seems to be based on the above assumptions as well as structural and organizational aspects of the system.

6. *Case Handling.* Responsibility for planning and coordination, referrals and/or court petitions, and on-going delivery of services to chil-

[3] Admittedly, economic considerations are germane to administrative decisions regarding program operations; however, economic criteria have not been utilized in this evaluation primarily due to limited time, funds, and manpower and a lack of conceptual clarity for cost-efficiency analyses of social services systems.

dren and their families, i.e., follow-up, are elements of the case handling function.

7. *Record Keeping.* Record keeping is the process of maintaining data which can be utilized for the general purposes of accountability, showing effectiveness of services, and for internal decision-making functions.

Evaluation Criteria. The following set of criteria has been used in evaluating how the systems operated in terms of the functions. This list of criteria is in no way considered inclusive, nor does every criterion relate to the evaluation of every activity.

1. *Expediency as a Criterion.* This criterion refers to the immediacy with which the mandated protective service system responds to reports of abuse or neglect. The measure of expediency was determined by a consideration of the time which expired between the time the report was received and the time of official action, i.e., investigation. The data for these calculations were obtained from case records. Beyond this, a determination of expediency was based on the existence of intra and interagency linkages and coordination in the response process.

2. *Compliance as a Criterion.* There are two aspects of this criterion. First, incidence coverage is defined as the extent to which cases identified by collateral systems are reported to the mandated protective service system. Secondly, investigatory coverage refers to the extent to which the recipient of reports investigates relevant cases. To determine incidence coverage, we considered the question of who may and who does report to the mandated protective service system. Similarly, respondents in the collateral systems were asked if, when, to whom, and under what circumstances they reported identified cases of abuse and neglect. To determine investigatory coverage, the responses to the question, "are all cases investigated?", were considered. The question was asked in relation to neglect and abuse complaints.

3. *Efficiency as a Criterion.* Efficiency, generally meaning productivity of action with minimum waste, was based on the extent of coordinated and cooperative efforts in internal operations and in relation to the parent agency and to the external environment. To determine the nature of such relationships, interviewees in the protective service system and in the collateral systems were asked to describe procedures of operating from the point of identification. Further, the respondents were asked if the outlined procedures were uniform/routine. In addition, a comparison of system's personnel performing functions was considered.

4. *Operational Definition of Abuse and Neglect as a Criterion.* An operational definition of what constitutes abuse or neglect was considered to exist if the following conditions were present: 1) written policy describing conditions and priorities set for responding to reports, and 2) case handling predicated on a distinction between emergency intervention and long-term services. Beyond this, gross inconsistencies among respondents to the question, "If cases are confirmed as a result of investigation, what actions are then taken by your agency?", suggested a lack of definitional clarity. Interviewees were asked to consider a list of abusive and neglectful situations having serious and non-serious consequences for children.

Contributory Factors. The following factors have been viewed as variables which may explain, in part, the way the systems operated in relation to the functions:

1. Case handling by the external environment.
2. System structure (including linkage to the parent agency).
3. Organizational behaviors (including operations in relation to the external environment).
4. Constraints (including lack of knowledge and training, lack of coordination and cooperation, legal constraints, and limited funds and manpower).

Evaluation of Effectiveness

In order to evaluate a system's intervention, i.e., services rendered, a set of criteria has been conceptualized

which will allow inferences to be made about effectiveness. These criteria are:

1. *Recidivism as a Criterion.* The extent to which children do not return to the system as measured by the absence of subsequent reports is considered an indication of the effectiveness of intervention. We acknowledge the fact that the inability to control for such relevant variables as family mobility, failures in the reporting system, and the occurrence of injuries not detected by potential reporters, lessens the validity of recidivism as a criterion.

2. *Severity of Subsequent Injuries as a Criterion.* This criterion is predicated on the belief that if services are effective, subsequent reported incidents will involve injuries less serious in nature than prior incidents.

3. *Length of Time Between Reported Incidents as a Criterion.* Longer periods of time between incidents is considered a measure of effectiveness. Here, too, the factors associated with recidivism as a criterion warrant that inferences be made with caution.

4. *Rehabilitation of Perpetrator as a Criterion.* To the extent that reported incidents do not involve the same perpetrator(s), we infer that services were effective.

5. *Disposition of Agency as a Criterion.* In utilizing agency disposition as a criterion, the assumption is made that subsequent dispositions will either remain the same or be less severe, e.g., services in the home over against removal, than earlier dispositions.

The limitations of the above variables as measures of effectiveness are both realized and acknowledged. It is understood that the best measures of effectiveness would be those which indicate some direct impact on the lives of the children and their families, e.g., growth and development factors, family rehabilitation, etc., over time (longitudinal design). A less accepted, though perhaps more direct than the present study design, would involve post-measures of subjects who have been abused or identified as abusers. For the scope of this study, neither avenue was open. Thus, while the present study (Level II data) has the advantage of a time-series look at case data in terms of reported incidents, a major weakness with respect to the evaluation of effectiveness has been the lack of measures of personal growth and development.

Protective Service Delivery Systems Studied

Data for this study were collected in two sites -- Nashville, Davidson County, Tennessee and Savannah, Chatham County, Georgia. In Site I, Nashville, Davidson County, Tennessee, an emergency 24-hour reporting system with a unique protective service program (CES-Comprehensive Emergency Services) has been in effect since 1971.[4] As a basis for planning for the program which was funded as a demonstration project by the Office of Child Development, H.E.W., the Urban Institute of Washington, D.C. conducted a study of neglect and dependent children in Metropolitan Nashville in 1970-1971. In Site II, Savannah, Chatham County, Georgia, the protective service system is a more traditional one with no internal provision for 24-hour emergency reporting within the public welfare system.

Data Sources and Research Procedures

This research project was conceptualized in two levels. The primary goal of Level I was the delineation of the systems' mechanisms for the identification and the handling of child abuse and neglect cases, i.e., program structure and organization. The major goal of Level II was to determine the nature and effectiveness of the systems' intervention.

Level I data which served as the data source for the analysis of system's operations or process issues were obtained from several sources in each site. In Nashville, these kinds of data were obtained from interviews with CES personnel, direct on-site observation, and two major reports: 1) one representing findings from an evaluation study of protective services in Nashville,[5] and 2) an in-

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[4]Comprehensive Emergency Service will be referred to as CES in the remainder of this report.

[5]Martin R. Burt and Louis H. Blair, *Options for Improving the Care of Neglected and Dependent Children, Nashville-Davidson County, Tennessee.* (Washington, D.C.: The Urban Institute, 1971).

house survey of medical facilities.[6]

In Savannah interviews with instruments of a structured and semi-structured format were conducted with administrative and service workers in the protective service unit of DHR,[7] with similar level personnel in the police department, in four hospitals and the public health department, and court workers. Additionally, on-site observations of the system's operations were utilized. Thus, the data for the operations or process component of the two systems are not from entirely comparable sources. Obviously, having embarked on a research effort of a project for which evaluative research had been conducted as in the case of Nashville's CES project and a system on which similar research had not been carried out, we could not utilize the same type of procedures as if we had conducted our research activities in two sites with similar programs and at similar stages of program development. Actually, one of the values in the study, we feel, is in the comparisons we will be able to make in this and subsequent reports of two very dissimilar systems for the delivery of protective services to abused and neglected children. Beyond this,we do not feel that the efficacy of the findings is violated by this approach for two major reasons: 1) the exploratory design allows flexibility in the data collection process, and 2) the systems' flow charts, constructed as a result of the data collected and the on-site observations, were reviewed for accuracy by project personnel with system's representatives in each site.

Level II data, which will serve as the data base for issues relevant to systems input, output, and outcome, were obtained in each site through structured interviews with protective service staff and a structured questionnaire to which case data were transferred from agency records. These data are presently being computer processed.

Focus of this Report

This report summarizes the operations, i.e., process component of each county's protective service delivery system. We have concerned ourselves with such issues as entrance into the system, which involves an analysis of the relationship between major collateral systems and the protective service system, and mechanisms for handling children within the system. Comparative analyses are made and recommendations offered.

A subsequent report will be an attempt to bring all the system's components, input-process-output, together in a holistic picture. While such an initial effort would be desirable, we felt that there is much to be learned from a comparative analysis of the systems' operations, the successes, the frustrations, and the failures. Further, we felt it unjust to delay these findings until the monumental task of analyzing Level II data has been completed.

Major Considerations

The delivery of protective services is viewed as a process involving an identified system; namely, the protective service unit of the public welfare department, having both an internal and external environment. An assessment of collateral systems, i.e., a vital part of the external environment, is necessary to gain an understanding of how the "service delivery system" takes in inputs across boundaries, what the constraints are, etc.

A second consideration must be strongly emphasized. We are herein stating clearly and explicitly that our research effort in Nashville, Davidson County, Tennessee has not been an evaluation of CES as a conceptual framework for the delivery of protective services.[8] In terms of the objectives guiding CES as a demonstration project, evaluation studies by Marvin Burt and Ralph Balyeat have indicated program success.[9] The present study has been an attempt to analyze the operating CES program from a broader context of protective service delivery in Nashville from the perspective of the systems model. The CES system is being compared to the formal system of protective service delivery in Savannah, Chatham County, Georgia. *Thus, the objectives guiding this*

[6] *Survey of Twelve Hospitals, Nashville-Davidson, County, Tennessee.* Report prepared by Donna J. Drinnon, Region V, Tennessee Department of Public Health (October, 1973). The survey was conducted in October-November, 1972.

[7] DHR refers to the Department of Human Resources which is Georgia's department of public welfare services. Throughout the remainder of this report we will refer to the Department of DHR.

[8] When the grant funds for CES as a demonstration project ended, a national grant was obtained for the purpose of dissemination of information on the CES system and the development of training packages for communities desiring to set up similar programs.

[9] Marvin R. Burt and Ralph Balyeat, "A New System for Improving the Care of Neglected and Abused Children," *Child Welfare*, Volume LIII, Number 3, (March, 1974).

study have been imposed upon the systems analyzed rather than reflecting the explicit objectives of either system. Therefore, any findings cannot be construed as an indictment of either system. This consideration will take on more meaning in the planned subsequent report.

A third consideration involves the data for this report. Inasmuch as we interviewed different actors within several systems, we found conflicting accounts about given operations -- especially among systems. Between-system conflicts can be viewed as a result of actors in systems describing systems from their own perspective. Such conflicts serve as a proper source of insight into the operations of the community system, i.e., multi-agency network. On the other hand, intra-system conflicts are less easily resolved. We have tried to resolve these as much as possible through consultation during the data aggregation and report writing stages. Needless to say, there is an element of subjective interpretation in our final report, but we have made every attempt to describe the systems accurately.

Limitations of the Study

One of the major limitations of the study rests in our failure to assess the problem from the perspective of educational systems, i.e., day care, elementary school, etc. This failure, however, is not an indication that these systems are insignificant, especially as a source of detection and input into the recognized protective service delivery systems. For indeed, school systems have children under direct observation and tutelage longer than any other societal system with perhaps the exception of the family. This failure is attributed to the lack of manpower, time, and funds. For the same basic reasons we were unable to assess the problem from the perspective of private physicians.

To the degree that different data sources have been utilized to compare the systems on some aspects, the investigator can be charged with making unwarranted comparisons between two dissimilar programs and drawing inappropriate conclusions. However, realizing the ultimate objective to be gained from insights gathered in the study, i.e., that of developing and/or improving models for training and service delivery systems, any conclusions drawn will be directed toward that goal rather than as a direct assessment of either system.

Chapter 4

CES – NASHVILLE, DAVIDSON COUNTY, TENNESSEE

For protective service systems to fulfill their mandated responsibility, each suspected case must be conscientiously handled from start to finish, i.e., from the receipt of the report or complaint to the investigation, to emergency action and court proceedings if warranted, and to the strengthening of the family, if possible, through support services. In order for this mandated responsibility to become a reality, a network of community interactions beyond the boundaries of single systems must be coordinated. The first part of this section deals with the relationship of CES to collateral systems.[1]

Relationship of CES to Collateral Systems

CES and Health Systems

Health systems, especially hospitals, are a major potential source for the recognition of abuse and neglect and for input into a community's protective service delivery system. The extent to which a hospital or other medical facility deals with child abuse and neglect depends, in part, upon the occurrence and definition/identification of the problem and the operating mechanisms for handling the cases.

Both of the above issues have been assessed in Nashville. From a survey of medical facilities, all, with the exception of two private hospitals, indicated an increased awareness of child abuse and neglect. Of more importance were some of the major problems viewed to restrict appropriate case handling. Seven of the ten hospitals indicated a need for standardized procedures for handling abuse and neglect cases. Four facilities expressed concern over the lack of cooperation from private physicians. And eight facilities needed more information on the "protective service" system's philosophy and the defined procedures for case handling, e.g., who should be called.[2]

The findings from the survey corroborated those expressed in interviews with CES personnel who indicated that there was no uniform procedure for getting abused and neglected children seen in hospitals into the CES program. Over the life of the project there were few referrals from private physicians; however, reporting from hospitals improved with child abuse referrals being doubled during the third project year of CES.

A common recommendation from the persons interviewed in the survey of medical facilities was the need for educational experiences, e.g., workshops. Since the completion of the survey, several multidisciplined child abuse workshops have been held in Davidson County as well as other counties in Tennessee. These workshops have been attended by medical personnel, students, social service workers, and an assortment of others. The workshops and continued efforts by CES have affected the relationship between medical facilities and CES in a positive way.[3]

A rather ill-defined relationship existed between CES and the public health department. One such center included in the survey of medical facilities expressed a need for uniform approaches to the problem, i.e., identification, case workup, referral procedures, etc. CES personnel related that all prematures dismissed from the hospital were referred to public health, but the procedure for referral and follow-up was not uniform. Beyond this, CES personnel felt referrals were made to CES only after or at the point where public health felt placement to be inevitable.

Another communication gap existed between CES and mental health facilities. According to CES personnel, there was no routine procedure for interagency cooperation. The primary need for mental health, as viewed by CES personnel, was to perform psychiatric evaluations, e.g., to determine whether or not a person was psychotic. Reportedly, mental health was generally re-

[1] Admittedly, many changes have occurred since the research was completed. Every effort, through consultation during the report writing stage, has been made to indicate such changes.

[2] Drinnon, *Survey*.

[3] A discussion of recent efforts designed to bring about a more desirable relationship between hospitals and CES is presented in Chapter 6.

luctant to accept CES referees especially in relation to physical or sexual abuse. It was felt that they were being requested to evaluate a situation in which what was revealed could be used to determine whether or not a child would be removed from his/her home. Beyond reluctance to accept referees, the time involved in getting eventual requested evaluations was lengthy. This situation caused great concern, especially when case handling was directly dependent upon such an evaluation. Further, this situation was not helped by the law which stipulates that all abused children are to receive psychiatric evaluation; however, there is no mechanisms in the law to deal with payment for these kinds of services to persons who are not active AFDC cases.

Another observation made by research staff, during the process of studying cases for Level II data, and corroborated by CES personnel was the virtual lack of referrals to CES from mental health facilities.

The above discussion appears to highlight the point that while medical facilities, i.e., collateral systems, are indeed a major source for the identification of abused and neglected children and a major source for input into the CES protective service channel, the latter factor generally stands as a potential rather than a reality.

These observations from both sides of the relationship have added new insight into the problem. It appears that a great deal of the between boundaries failures can be directly attributed to a lack of interagency coordination. This appears especially to be the case between CES and the hospitals from which a common expressed need was for more information and uniform intra and interagency procedures for case handling. If this observation represents the reality of the situation, it appears that the situation could be remedied, in part at least, by a concerted effort to duly acquaint the medical community with aspects of the law and the mechanisms set up by CES to handle reported cases, i.e., how, where, and to whom to report? Concomitantly, medical facilities appear to need technical assistance to help routinize their own internal operations.

On the other hand, it appears that while a lack of coordination may be viewed as a contributing factor in the less than desirable relationship with the mental health element, a more important factor may be that of a lack of cooperation, e.g., the perceived existence of differences in systems' philosophies, the resistance to changing roles and functions possibly perpetuated by the provisions of the law. Perhaps a closer worker relationship between agencies could eliminate the former, while administrative changes may remedy the latter.

The extent to which input from the medical community, a major potential source into a protective service delivery system, is hindered is one indication of the extent to which a community deals with the problems of child abuse and neglect. This would suggest that as a community moves in the direction of implementing a CES program, complete knowledge of the law, of protective service philosophy, objectives and functioning as well as technical assistance should be provided to hospitals and other medical systems in developing standardized procedures for inter and intra-agency case handling.

CES and Law Enforcers

Many cases of child abuse and neglect routinely come to the attention of a community's police or other law enforcement agency.[4] Some such cases result from reports made directly to the police or sheriff's department; others unfold as law enforcers pursue situations involving adults in police matters, e.g., domestic altercations, criminal behaviors of parents or guardians; and still others are recognized by officers as they routinely patrol their assigned territory. At any rate, in lieu of training and/or administrative procedures, officers would probably handle such cases, howbeit from a personal orientation, according to prescriptions in the law.

According to Tennessee's child abuse reporting law, child abuse is a misdemeanor carrying a fine of not more than one thousand dollars or imprisonment of not more than eleven months and twenty-nine days or both.[5] One can surmise that a rehabilitative orientation among officers will be less likely to occur smoothly and quickly

[4] In Nashville, Davidson County, Tennessee, it is reported that prior to the implementation of CES, police officers "....actually signed the petition in approximately one-third of all neglect/dependent cases and frequently picked up the children, took them to the Juvenile Court, and then to Richland Village." *Community Emergency Services: Community Guide*. pp. 14-15.

[5] Public Chapter No. 81, Senate Bill No. 160, Section 6. Chapter 10 of Title 39, Tennessee Code Annotated (April, 1973).

when a punitive element exists in the law than when such a constraint does not exist.

Initially one of the poorest areas of cooperation was that which existed between CES and the police department. Common kinds of situations which initially caused CES personnel grave concern involved those arising out of public transient incidents and those which were police oriented. In such situations, CES was usually called into the case after parents were jailed and the child/children were inappropriately "disposed of." On the other hand, if cases were child oriented, with the exception of severe physical or sexual abuse, police officers referred cases to CES.

The relationship between CES and police officers reportedly improved significantly over the life of the program. Presently, CES personnel indicate that police officers consult CES or the Juvenile Court more frequently; and only in extreme cases will the above described channel of case handling exist.

That police department personnel were included in the planning prior to the implementation of CES in Nashville, one could surmise that a lack of cooperation, due in part to the prescription in the law and the lack of training in the area of abuse and neglect for direct line officers, rather than a lack of coordination contributed to the initial problems between CES and the law enforcement system. Improved relations between the two systems have resulted, in part, from the continuous efforts of CES personnel to involve law enforcement personnel more directly. Training, for the most part, is yet lacking which is probably the case in most communities.

Undoubtedly, law enforcement systems are a major potential source for input into the protective service delivery system regardless of the stage of development in which the system may be. In considering the CES system or some other for implementation, there are several factors to be worked out. In communities where there is no coordinated system for the delivery of protective services there will be the need to develop interagency procedures for case handling, i.e., protective service and law enforcement. Concomitantly, training for law enforcement personnel in general and line officers in particular is vitally important. Where coordination exists, efforts toward continuous open communication toward the goal of cooperative relations must be expended. Training of law enforcement personnel is essential.

In any event, developed case handling procedures as well as training provided would need to be worked out with careful consideration of the prescription in the law.

CES and the Juvenile Court

Prior to CES, DPW often became aware of situations after neglect/dependent petitions had been filed, i.e., no involvement prior to the petition.[6] However, with the implementation of the CES demonstration project a close coordinated system was instituted. Each case defined as an emergency reportedly, is assessed immediately in the field by the CES worker on call and the protective service worker from the Juvenile Court. If such a call is taken at the Juvenile Court intake, the CES worker is notified; both workers investigate the situation as in cases initially reported to CES intake.

CES Systems Operations

The CES system does not constitute a new set of services; rather, a unique way of coordinating services with the emergency intake services being perhaps the central coordinating unit of the system and its components. This section is devoted to a description of the Nashville, Davidson County, Tennessee system's operations, i.e., process in the handling of abuse and neglect cases. Reference to Figure 1 in Chapter 6 should assist in understanding the system's operations. It must be emphasized, however, that the project was designed as a crisis/emergency intervention system. As such, child abuse and neglect situations constitute only a part of its focus.

The definition of comprehensive emergency services as established by the Metropolitan Nashville CES program follows:

> Comprehensive Emergency Services is defined as a child welfare service designed to meet any family crisis or impending crises which requires social intervention for the purpose of planning to protect children whose health, safety, and/or welfare is endangered with primary emphasis on those children who will reach the attention of the Juvenile Court, as neglected, unless there is immediate casework interven-

[6] DPW refers to the Tennessee Department of Public Welfare.

tion.[7]

CES Service Components

The initial CES program in Nashville was comprised of four basic service components:[8]

1. *Twenty-four Hour Emergency Intake.* This service was designed as an answering service to screen calls for referral of emergencies to the caseworker on call. In actual operation, intake workers in the Nashville program were responsible for initial case handling in most cases and outreach and follow-up in a large proportion of cases. Reportedly, each intake worker carried an active caseload of approximately forty families. The service of emergency intake is especially important for nights and weekends.

2. *Emergency Caretaker Services.* Caretakers were to provide temporary care, usually for only a few hours, in unforeseen emergencies which occur at night leaving children without parental supervision. According to CES personnel, this service was never fully developed; homemakers eventually took over caretakers' roles as functions began to overlap.

3. *Emergency Homemaker Services.* These services are provided on a twenty-four hour basis for the purpose of maintaining children in their own home until the resolution of a crisis which makes it impossible for the parent to carry out his/her routine parental responsibility. In the Nashville project, emergency homemakers proved to be an important component in the total program. It is reported that during 1973, "eleven homemakers provided services to 134 families maintaining 525 children in their own homes."[9]

4. *Emergency Foster Home Services.* These services were designed to minimize the emotional shock of the removal of children from their own homes by providing them with a home environment as an alternative to the routine housing of all children temporarily in an institutional placement prior to court hearings. Emergency foster homes differ from regular foster homes in that they receive children at any hour and usually without preparation such as preplacement visits. Children are usually placed for shorter lengths of time. Two major types of problems in the utilization of emergency foster homes emerged. Emergency foster home space had to be used to provide care for children whose regular placements broke down. Another problem area involved children who because of their age and/or emotional problems were able to adjust to a particular emergency home and were, therefore, allowed to remain in that emergency home because it was determined to be the most suitable placement. These kinds of situations undoubtedly placed a demand on the supply of emergency space.

The Intake Process

"The twenty-four hour emergency intake is the component which provides the central mechanisms necessary for coordination....The emergency intake is the main thrust for the system and its components."[10] Entrance into the system occurs through the intake component.

During Work Hours. -- Complaints received during the work day were studied, from information received from the walk-in or telephoning complainant, by the emergency service intake worker. The intake worker had the responsibility for determining the most appropriate action from several alternatives. Some cases were referred to other community resources. In cases appropriate to the services of CES which were determined, from

[7] *Comprehensive Emergency Services: Community Guide*, P. 1. For a detailed description of the services, see Chapters 9 through 16.

[8] For a full description of these components and operating program cost information, see *Community Guide*, pp. 47-52. Also, see Chapters 12 and 16 for a description of components added to the initial program, Emergency Shelter for Families and Adolescents, respectively.

[9] *Community Guide*, p. 49.

[10] *Ibid*, p. 77.

available information, to be non-serious in nature, social services were offered. In such instances, intake and investigative work were conducted by the emergency intake worker. However, the intake worker was not generally responsible for carrying such cases. Each case defined as serious or an emergency was assigned by the intake worker and the supervisor for immediate investigation and assessment.

After Work Hours. – Complaints were received through the DPW emergency intake answering service which, upon preliminary screening, referred some calls to other community resources and emergency or crisis situations to the emergency intake worker "on call." The intake worker determined, from available information, the nature of the situation. Non-serious/non-emergency situations were either referred to appropriate agencies or to outreach and follow-up. Emergency situations were assigned for immediate field investigation.

Screening and Investigative Processes

The screening process determined the expediency with which calls or other sources of complaints were investigated in the field. The expediency with which calls were reportedly investigated depended upon the degree to which a case was defined as an emergency. Project personnel indicated that the following types of situations were categorically earmarked for immediate intervention: (1) reports of children left unsupervised or improperly supervised; (2) child abuse; (3) children without proper nourishment, shelter, or care (gross neglect); (4) children in need of immediate planning due to severe family conflict and disorganization; and (5) family crises involving situations which might result in children going before the court. Neglect complaints, not falling within the above types, were not assigned for immediate intervention; they were generally routed to the regular DPW protective service unit for investigation.[11] Non-serious/non-emergency cases were investigated by the emergency intake worker much on the order of neglect complaints.

To determine if a pattern of intervention actually existed as a result of screening, we have analyzed initial Level II data which suggest that seriousness and, to a lesser degree, knowledge of case history influenced the expediency of the investigation. Analyzing two decks of case data – Deck 1 being serial abuse cases (N=86), and Deck 2 being cases on which only one incident had been reported (N=103) – we found that Deck 1 cases were generally investigated more quickly than were Deck 2 cases. Investigation was initiated in less than twenty-four hours from the receipt of the complaint in 80.2 percent of Deck 1 cases and in 78.6 percent of Deck 2 cases. Seemingly, the most important criterion for prompt intervention was that of seriousness in serial abuse/neglect complaints. While an overall 80.2 percent of Deck 1 cases were investigated in less than twenty-four hours, 86.3 percent of serious and 77.2 percent of non-serious cases were investigated within that time period. There was no real difference between the time of intervention of serious and non-serious cases in Deck 2, 79.7 and 77.3 percent, respectively. In only 3.5 percent of Deck 1 cases, involving non-serious conditions, did the initiation of the investigation occur after a period of one week but less than one month. In Deck 2 cases, the investigation was initiated after one week but less than one month in 6.8 percent and in 1.0 percent of the cases after one month.[12]

Each case, defined as serious or an emergency at intake, was assessed immediately in the field by the emergency intake worker and the protective service worker from the Juvenile Court. If an emergency call were received at the Juvenile Court intake, the CES emergency service worker was notified. A cooperative field investigation, i.e., the Juvenile Court worker and CES worker, was reportedly conducted in all situations defined as emergency/serious/crisis. This procedure was followed for complaints during and after work hours. From an evaluation of a situation occurring after work hours, a decision was made regarding the considered most appropriate action, i.e., service. The case was subject to further study the following work day. The main point to be taken note of here is that interagency, i.e., CES and Juvenile Court, procedures have been defined and appear to be in operation for initial case handling after entrance

[11] These specific priority types of situations have been broken down into more detailed types. See *Community Guide*, pp. 7-8.

[12] These kinds of data, as well as data concerning expediency by type of situation, will be analyzed more extensively in the anticipated subsequent report which will be based on case data. The total number of cases in these analyses do not include cases for which unknown was reported for either variable under analysis.

into the CES system.

Case Assignment and Handling

Cases were assigned primarily on the nature of the complaint. While the intake and investigative work on non-serious/non-emergency situations was conducted by the emergency intake worker, these types of cases were normally opened and carried by some other unit of DPW (general service or regular protective services) if services were accepted. *Aside:* these units were not a functioning part of the demonstration CES project. Although present in a small number of situations, the refusal of the services could lead to the recommendation that a petition be filed.

Cases initially defined as serious/emergency/crisis were opened and carried by emergency intake workers. For these cases, the worker had the responsibility of investigating, diagnosing, planning, coordinating with supervisors of program components for services to children and their families, and on-going case handling. Case transferral, as we will note in a following discussion, beyond the defined crisis was hampered by definitional and administrative problems.

Record Keeping

The importance of record keeping in any venture has been recognized; but perhaps in no area, more than that of the delivery of public social services, does this tool take on such paramount significance. Public social service agencies are increasingly being made aware of the need to maintain data which can be utilized for the general purposes of accountability, showing effectiveness of services, and for internal decision-making functions.

Initially, the CES project utilized three major forms of record keeping:

1. Family folders, which included narrative accounts of case movement and relevant case forms, e.g., medical service forms, court decrees, etc., were maintained by the emergency intake workers on all cases which were opened and carried by them.

2. A brief report was maintained in the emergency unit on all cases for which emergency intake conducted the intake and investigative work, but did not open if it were possible to pass to the parent agency.

3. "Green carding" was applied to cases which were not validated upon investigation or for which there was a minimum of information to show accountability.

As a result of a directive from OCD, the federal funding source, this latter method was eliminated in 1973.

A log was maintained to serve as a central file for all complaints reported to CES intake. Each time a complaint was received, the child's/children's name was added to the log. This is to say that the total number of cases on the log at any given time represented isolated and serial abuse/neglect complaints.

Any manual record keeping system, as computer systems, will fall short of the desirable. But the degree to which the manual system maximizes the use of relevant information and the ease of retrieval, conversion to a computerized system will be better facilitated.

The main criticism of the CES record keeping system is twofold:

1. The log should provide an easy means to abstract information on actual case count and case count on specific variables.

2. The log only contained "cold" facts; the "hot" facts were imbedded within the mire of the workers' folders.

I must emphasize here that the criticism has been made as a point for developing systems to note. The Nashville CES project was the first of its kind in the nation; thus, beginning projects should gain from their initial failures as well as successes.

Some Observed Problems

Problems in Case Transferral

While, indeed, CES is and can legitimately be considered a system, it is important to the following discussion to relate to our discussion on the systems model. In analyzing a system, it must be recognized that the system under study is a part of a network of subsystems,

systems, and suprasystems. And so it is with CES. The CES project was a federally funded demonstration project under the auspices of the Davidson County Department of Public Welfare.[13] The major operations were housed in a building adjacent to the County Department Office Building. While CES, then, was a system it was at the same time a subsystem of the Department. A special problem, however, resulted from the relationship between the project and the parent agency. The problem in question involved the transfer of cases from CES to components of the parent agency. CES personnel were in no position to "force" cases on the general service or regular protective service units if these units refused to accept them. With this inability to transfer cases when needed, each emergency intake worker carried an average caseload of 40 cases, i.e., families.

Another factor which contributed to the heavy caseloads was the problem the project faced in defining a crisis, i.e., should the transfer of cases to general services or the regular protective service unit be time or case oriented? The major question was should CES remain strictly intake and assessment or should it follow cases at various stages? What ends the crisis stage? Essentially, this was never resolved; what actually existed was workers carrying heavy caseloads and having to plan for separate cases falling at different points in the protection process, e.g., children not placed, those placed, and those in the court process.

In terms of problems in the transfer of cases between CES and the parent agency, one could hypothesize, that in view of the fact that coordinated procedures had been worked out prior to the implementation of the project, the problem existed primarily due to agency resistance to changes in roles and functions. A recent interview with personnel from the parent agency indicated this was a factor, "agency personnel were not as knowledgeable about the project as they should have been." A further interesting hypothesis would be that there would be fewer barriers to case transferral under present arrangements for CES than under previous operation as a special demonstration project.

While the problems in case transferral contributed to heavy caseloads for emergency intake workers, the workers also contributed to their own dilemma, i.e., defining a crisis in broad long-range terms. I perceived, from observation and interviewing, two major reasons for cases being carried on a long-term basis as a "crisis" situation: (1) CES never developed a definition of crisis in operational terms, and (2) emergency intake workers operated as social caseworkers in feeling the need to see some cases through. Both of these kinds of situations would appear to be correctable through technical assistance for the former and, for the latter, on-going training with respect to the developed definition.

Problems in the Intervention Process

The intervention process is fraught with problems based primarily on decisions regarding the existence of abuse and/or neglect, i.e., definition; the most appropriate immediate action based on the determination; and services to be provided to the child/children involved and the families. Undoubtedly, decisions in the latter two problem areas depend, in part, on decisions made on definition. However, it is in this area that child protection workers have few meaningful guides to their actions. Child abuse and neglect are ill defined in state statutes. Given the lack of appropriate operational definitions, child protection workers may find themselves involved in legal suits for exercising the authority to remove children against parents' consent when, in fact, decisions had been made that abuse/neglect existed and removal was necessary. On the other hand, if the decision is made to let the child remain in the home and subsequent serious injuries occur, the workers can similarly be indicted by society for inaction. And more to the workers' and the protective service agency's dismay is the fact that the courts have fewer guides in the process.

Such problems plagued CES workers throughout the project. The Director, in describing the nature of the problem, posed the following questions: "What constitutes abuse? Are there several pieces of evidence existing, e.g., visible injuries in conjunction with family problems; negative attitudes toward the child, etc.? When can you say with absolute certainty that abuse rather than an accident has occurred? What determines when and if you remove the child?"

The extent to which CES removed children, inappropriately by parents' and/or societal definition, cannot be herein documented. However, it was stated by several interviewees that the problem, especially from parents'

[13] Funds were terminated at the end of the project year in 1974. The program continues to operate on State funds.

perspective, was not a minor one.

This kind of problem points to the very nature of protective services. They are involuntary with the service providers placed on the firing line with inappropriate and inadequate ammunition. A viable knowledge base in this area is indeed an urgent need.

Problems in the Delivery of Services

CES is a service oriented program with its services being designed to intervene and ameliorate crisis or emergency situations. As such, the delivery of service by CES personnel, by definition, should be on a short-term basis. Owing to the basic problems previously discussed, services were often long-term. Beyond the emergency services for which CES was responsible, CES component personnel necessarily inherited responsibility for services to some families and children in situations where children were not placed, were temporarily placed, were in the court process, and were placed after court disposition.

Thus, in many cases CES was directly responsible for case handling for as long as ten to twelve months. According to CES personnel, hearings on petitions generally take up to four weeks. If custody for placement on a case was awarded to DPW or some voluntary agency, the delivery of services to the child and his family was rendered by emergency service components, with the major responsibility for the family remaining with the intake worker. The duration of temporary placement, when specified by the court decree, ranged from a minimum of ninety days up to six months. However, the court most often did not specify minimum/maximum time under DPW custody; time was usually left to the discretion of DPW. It was felt by CES administrative personnel that time should be stipulated by the court; not to do so allowed workers to lose sight on activities in terms of time frame designed to ameliorate the family situation in preparation for the return of the child. The lack of continuous and meaningful services to families while children were in placement was cause for concern among CES personnel. It was indicated that all too often services to parents were a "crash" program initiated just prior to the child's return to his home.

Summary Statement

CES as a conceptual model for the delivery of emergency services to families and children is indeed an improvement over existing models. It is the writer's hope that communities, in coming to grips with the emergent needs of children and their families, will adopt some model for crisis intervention. However, CES or any other model planners must be acutely aware of the fact that a model is a guide, a framework; actual operations may approximate the model or deviate substantially from it.

It is further hoped that this report on the perceived operations of CES in Nashville, Davidson County, Tennessee, and the description of the protective service delivery system in Savannah, Chatham County, Georgia will prove beneficial to community planners who anticipate implementing a CES program.

Chapter 5

PROTECTIVE SERVICE UNIT – SAVANNAH, CHATHAM COUNTY, GEORGIA

Unlike Nashville, Davidson County, Tennessee, Savannah, Chatham County, Georgia did not have an innovative child protection program. Protective services to children have been provided through a more traditional system under the direct auspices and as a part of the State's County Department of Human Resources (DHR). Like the CES system, however, the Protective Service Unit (PSU) in Savannah must be viewed simply as a part of the total community's approach to the provision of protective services. In the first part of this section we have taken a close scrutiny of the relationship between the PSU and collateral systems.[1]

Relationship of PSU to Collateral Systems

PSU and Health Systems

The extent to which health systems in Savannah were identifying and reporting abuse and neglect, and their procedures for case handling were assessed through interviews with health and social service personnel who worked within the facilities. Physicians, much to the investigator's dismay, were not interviewed.

The actual extent of the problem of child abuse and neglect was not quantifiable in that the surveyed medical facilities did not keep a file on suspected cases. However, to the question, "Are you seeing physically abused children?", all respondents answered in the affirmative. Interviewees from the private hospital qualified their response by indicating that such cases were occasionally seen. Respondents from all facilities, however, indicated that there appeared to be an increase in the number of abuse cases seen.

Of more importance were the insights gained in relation to reporting. In none of the health facilities was physical abuse, of a non-serious nature, reported to PSU. Yet, these same facilities also indicated that there were no in-house services available to parents who were suspected of abusing their children. On the question of serious physical injuries, suspected to have been caused by abusive actions, the majority of the respondents indicated that the parent or other suspected abuser was "sometimes" reported.

A matter of grave concern with respect to reporting was that of the internal procedures for case handling. There was not a routine procedure for intra and inter-agency reporting of suspected cases of abuse. From the responses given, it appears that key decision-makers and case observers in the hospitals were medical personnel in the emergency rooms and pediatric services. However, in the absence of hospital based programs designed to deal with the problem and the evident lack of efforts to increase key hospital medical personnel's knowledge and awareness of the problem, it is no wonder that the course of action with regard to abuse cases was referred to as "lacking uniformity and predictability."

The reporting of neglect cases appeared to be as haphazard as that of physical abuse. All the medical facilities indicated that neglect cases were seen; however, there were no criteria for defining reportable medical neglect and no routine procedure for reporting. Only one respondent suggested that a report "might be made" if neglectful conditions were serious in nature. As with abuse incidents, files were not maintained on suspected neglect cases.

The failure of medical facilities to report was also established by PSU personnel. It was indicated that on the rare occasion when reports were made, the referral was most often made to law enforcement rather than social service workers.

To what can the lack of reporting by medical facilities, as verified both by the surveyed facilities and by PSU personnel, be attributed? Undoubtedly, there were a number of factors. However, it appears that from expressed concerns and problems, one factor was not complacency or unawareness on the part of health facilities.

[1] As with the CES system, we have taken every precaution, through consultation during the report writing stage, to indicate aspects of the system which have undergone change since the completion of the research. Certainly changes in the higher system, the State Department of Human Resources, will affect local operations.

Rather, the situation was viewed as unsatisfactory from their perspective. For, indeed, each interviewee in the facilities expressed the need for criteria for assessing abuse and neglect cases. A related concern involved the failure of the facilities' physicians to report. In two of the hospitals surveyed, it was indicated that pediatric and emergency room physicians worked out such cases with the child's or family's physician rather than through reporting. Both of the above concerns suggest to me the need for education and training. Beyond this, a uniform procedure for case handling, involving the total medical system, needs to be developed and made operative. Most certainly, every interviewee recognizing this urgent need, expressed the desire for standardized procedures for inter and intra-agency case handling.

While we did not assess the extent to which the mental health system served as an input source to PSU, we attempted to determine the nature of the relationship from the perspective of PSU service workers. The relationship was described as a cooperative one. The major responsibility of mental health components, as reported by PSU personnel, was that of psychiatric evaluations and on-going treatment when the need existed. One worker, however, expressed deep concern over the value of the psychiatric evaluations. From the worker's perspective, the evaluations were a "carbon copy" of the worker's assessment which was required before the evaluation was rendered.

The preceding discussion, as that of the health facilities in Nashville, indicates that while such facilities are a major source for the identification of abused and neglected children, they have fallen short in their input capacity to the community mandated protective service agency. The seriousness of underreporting was especially noted in the survey of health facilities in Savannah where it was indicated by a majority that serious suspected abuse "might be reported" and only one respondent suggesting that serious neglectful conditions might be reported.[2] A great deal of the failure appears to be attributable to a lack of intra and interagency, i.e., system coordination. We would suggest that training and the development and operation of uniform procedures for case handling would ameliorate the situation. Beyond this, PSU personnel could initiate or increase efforts to educate health facilities to the nature and philosophy of protective services, the attending laws, and the Unit's procedure for case handling. Indeed, what has been learned from this survey points to a lack of knowledge and coordination rather than a lack of cooperation between PSU and health facilities.[3]

PSU and Law Enforcers

Interviews with police officers, as with protective service workers, revealed that a good cooperative relationship existed between the law enforcement and protective service systems on abuse and neglect cases *where there appeared a need to work together,* i.e., when police requested PSU's aid the assistance was satisfactory, and vice versa. What seemed to come through; however, was from a procedural standpoint, there were confusions and ambiguities on when and how to get cases from the law enforcement system to that of protective services. Reportedly, much of what happened in case handling depended on factors such as who the sergeant on intake might have been, the accessibility of an officer from the Children and Youth Division, and the kind of knowledge of resources possessed by the intake worker.

The above concerns regarding the process of case handling were emphasized by officers in such statements as: "DHR needs more people to work with us." "We need conjoint investigations." "We need better coordination between protective services, police, and the Juvenile Court, we are so far apart. As a consequence, some policemen don't know who to go to." And, indeed, similar concerns were heard from PSU personnel. "Police don't always report to us; they don't refer when they should." "The need exists for protective service workers and policemen to work together in the same office situation, if possible." "Systems' constituents are miles apart in philosphy."

With respect to neglect and dependent petitions, there appeared to be a more clearly defined process. For

[2]We must emphasize here that the extent to which reporting by health facilities in Nashville was influenced by severity of injuries was not determined from the Drinnon Survey which was conducted prior to our research. Further, the survey was not designed to differentiate between abuse and neglect. However, from the similarity of expressed concerns and problems, we surmise that the situation was probably not significantly different.

[3]The extent of actual reporting of collateral systems to the protective service agency in Nashville and Savannah will be explored quantitatively in a subsequent report which will be based on an analysis of case data.

the most part, DHR, rather than police officers, was primarily responsible for filing petitions. However, a child might have been removed from the home and temporarily detained before PSU was brought into the case. This latter point will take on more significance in our discussion of the Juvenile Court and the PSU's system operations. Law enforcers were the main recipient of complaints after DHR's work day and on weekends.

From the preceding discussion, it would appear that the lack of cooperation was not a major causative factor for the "unsystematic" handling of child abuse and neglect cases by law enforcement and protective service systems. Rather, there was a lack of well developed and uniform procedures for the coordinative efforts required for interagency case handling.

PSU and the Juvenile Court

With respect to the system for the delivery of services to abused and neglected children, it can be stated that there was no real system within the realm of the Juvenile Court. The services which were rendered were happenstance and tailored to each situation, and reflected the personal orientation to services of the court worker, rather than a coherent plan of interaction between agencies. It should be emphasized that the Juvenile Court regarded juvenile delinquency as its proper domain, with its primary and immediate responsibility being the rendering of services to the community through developing treatment modalities for delinquents and serving as a place of incarceration for misdemeanants and felons until their cases were formally adjudicated and disposed of. This means that the abused and neglected children were regarded as properly the responsibility of the protective service unit of the County Department of Human Resources, with the Juvenile Court having the responsibility of making adjudication on those children on whom petitions were filed.

While the philosophy existed that abused and neglected children should not be detained in the Youth Development Center (YDC), what in fact was the case was that situations developed whereby children were temporarily detained at the YDC who would have been more properly served elsewhere. Reference is made here to children who were found to be in a state of abuse or neglect who were placed for temporary custody at the Juvenile Court until something more permanent could be resolved.

One glaring problem seemed to be that of where domains begin and end. What are the responsibilities of protective service and what are the responsibilities of the Juvenile Court? The area between the accepted domain of each agency, that these two agencies confronted, was a den of confusion and could be a traumatizing experience for the child. An illustration of this point is warranted. The protective service office, through which services are rendered to abused and neglected children, closed at 5:00 p.m. A police officer who finds a child who has been abused or is in a state of neglect may have no alternative but to "place" the child in the detention center overnight or, if the incident occurs on the weekend, until the next work day when protective services can get into the case. The intervention of the protective service unit may or may not result in services immediately, since such factors as availability of children's homes or emergency foster homes have to be considered.

Juvenile court workers were hindered in their capacity to serve abused and neglected children by not being able to make investigations in the field. These workers expressed a need for more involvement with DHR in abuse and neglect cases. Workers were not clear on what protective service workers did and vice versa. There was not a clear communication of goals, purposes, and procedures. There was a notable absence of interfacing between DHR and the Juvenile Court on a routine basis. However, there was good cooperation between the systems when there existed a case of mutual interest, e.g., custody case.

PSU -- Systems Operations

In Savannah, Chatham County, Georgia, protective services were provided through the PSU which was designed specifically for the purpose of handling abuse and neglect cases. Like CES in Nashville, intake in Savannah's PSU was set up as a separate unit within the parent system. Unlike CES, PSU did not have at its immediate disposal other social work resources which could be brought to bear upon situations without bureaucratic red tape.[4]

The Intake Process

The Protective Service Unit of DHR provided for in-

[4]In the Fall of 1974, this system was extended in its functions to handle any crisis family situation in which children are harmed or at risk of harm. As such, child abuse and neglect constitute only a part of its present focus.

take during the work day (8:00 a.m. through 5:00 p.m.) five days a week. As previously indicated, complaints were handled by law enforcers after DHR's work day and on weekends.

During Work Hours. – To a large degree, the intake process served as the point of entrance into the system. It was at the point of intake that major decisions regarding initial case handling were made. The PSU intake worker had the major responsibility for determining the channel cases took, i.e., outside referral, other unit within the agency, or PSU investigation and intervention. The intake worker catalogued facts presented, weighed the facts, and made decisions based on the evaluation of the facts.

After Work Hours. – There were no provisions internal to the PSU of DHR to handle complaints after work day hours and on weekends. While law enforcement personnel received complaints and otherwise became involved in child abuse and neglect cases during DHR's work hours, they were the sole recipient of reports at other times.

Intake after DHR's work hours undoubtedly sometimes resulted in actions which could have "unnecessary" negative effects for children involved and their parents. Line officers in law enforcement most often indicated they would pick child up, remove, or make arrangements for removal in situations involving non-serious consequences for children. Further, in cases involving serious physical injuries which were not resultant of disciplinary measures, officers indicated they would try to get evidence against parents for criminal procedures. Unlike line officers, the chief administrator suggested that DHR would be called to handle cases except after their work day hours, on weekends, and in situations having serious consequences to children. In any case, when removal was handled by law enforcement personnel, DHR was generally notified the following work day.

Screening and Investigative Processes

Protective service workers assigned top priority to abuse cases for investigation. It was indicated in interviews that while procedural manuals exist for caseworkers, they mainly rely on "in-unit" knowledge. For the most part, workers were said to operate on the basis of personal criteria for determining what cases were to be investigated or if an investigation was to be initiated.

Workers in the PSU indicated that by and large all complaints of abuse were investigated; all neglect calls were not followed-up. On the other hand, law enforcement personnel indicated that while complaints of abuse took top priority for investigation, all neglect complaints were also investigated.

The expediency with which complaints were reportedly investigated depended, in part, upon the perceived emergent nature and subsequent case assignment. Cases defined as serious at intake were assessed as quickly as possible in the field by a PSU worker(s). Investigation by the PSU was only conducted if the complaint was of a new case and/or if the situation was defined as serious or an emergency.

While the initiation of investigations in Savannah was less prompt than in Nashville, time between the reported incident and investigation appeared to be influenced both by seriousness of injuries and by knowledge of the case, i.e., Deck 1 (serial abuse) and Deck 2 (isolated incident). Investigation was initiated in less than twenty-four hours in 69.4 percent and in 64.7 percent of Deck 1 (N=49) and Deck 2 cases (N=173), respectively. It appears that seriousness was the major determining factor for expediency in both decks of cases. Investigation occurred in less than twenty-four hours in 73.3 percent and 75.0 percent of serious Deck 1 and Deck 2 cases, respectively, and in 67.6 percent and 61.2 percent of non-serious Deck 1 and Deck 2 cases, respectively. The investigation was initiated after one week in approximately one-seventh of the cases in both decks.

If complaints received at intake were on active cases, previously referred, or not of an emergency nature, they were referred outside the PSU for the investigatory processes. The majority of active cases were referred to the worker assigned to the case. Other cases were assigned to the General Service Unit or some other appropriate unit of DHR. In such instances, active caseworkers other than a worker from the PSU assumed the responsibility for investigation.

Case Assignment and Handling

Clearly, the PSU was designed as an emergency intervention unit. This point is made in reference to function and case handling rather than to the Unit's ability to respond immediately to complaints. For we have noted earlier that in approximately one-fourth of all seri-

ous cases, the investigation was initiated after the first day.

Beyond intake and handling the identified emergency or resolving the immediate crisis, PSU workers were not responsible for case handling. Cases were then transferred to some other unit of DHR. In addition to this initial case responsibility, PSU workers consulted with and advised workers assigned to cases in which court action was involved.

As previously indicated, some cases which were received at intake were investigated by workers in other units of the agency. These categories of cases, unless further assessment revealed a need for "crisis" handling, were assigned to units other than the PSU. Regular caseworkers, assigned to active clients on whom reports were received, were responsible for investigating the complaint and for on-going case handling. Thus, these workers' tasks became that of protection (involuntary services) as well as general social and economical services to the family (voluntary).

Record Keeping

The PSU maintained a log which served as a file of "protective service" cases. When complaints were received at intake, the worker consulted the log as part of the determination for case assignment. Cases which were not designated as the proper domain of the PSU were not recorded on the log. This is to say that the log maintained by the PSU did not reflect the "true" incidence of child abuse/neglect. Further, given that non-serious prior reported and active client cases were deflected out of the Unit, a picture of serial abuse could not be obtained from this source.

Family folders were maintained by the worker responsible for case handling. These folders contained narrative accounts of case movement and relevant case forms. If the case involved children having been reported to the PSU for protective services, generally only one child abuse form would be included in the folder even if a study of the folder indicated that several complaints had been investigated. In other words, subsequent reports and/or complaints and actions taken were lodged within the mire of the workers narrative of the case process. Additionally, many active cases carried by general service workers, which had not been reported to the PSU intake, were, in fact, "protective service" cases.

We cannot over-emphasize the felt need of service providers to become more accountable to their clients and to the public, to demonstrate service effectiveness, and to make better and more appropriate internal decisions. These needs are affected not only by what is done but by adequate and accurate documentation of what is done and by the ease with which the documented information can be retrieved for utilization.

On the matter of documentation, we can posit two major criticisms of the PSU record keeping system. First, the PSU log should be utilized as a tool by which a more accurate picture of child abuse/neglect can be obtained. We are not, herein, suggesting that the PSU handles all cases received at intake; rather, that all such cases be documented at this point or at the point of case transference. Beyond more inclusive documentation at PSU intake, perhaps some procedure could be designed whereby complaints, which are not received at intake and are handled by caseworkers, can be referred to the PSU for documentation. Such a procedure would give a more accurate account of the reported incidence of child abuse and neglect as well as the degree to which protective services are being rendered by other units, e.g., general services. Secondly, as with record keeping in the Nashville, Davidson County, Tennessee CES system, the PSU log contained "cold" facts on the case and the "hot" facts were embedded within the caseworkers' family folders.

Some Observed Problems

The major problems observed in the operations of the Savannah, Chatham County, Georgia Protective Service Unit were necessarily of a different nature than the major problems observed in the CES system.

Unlike CES, which was initially a federally funded demonstration project and reportedly never completely accepted as an integral part of the parent agency, PSU was an important part of DHR, as an intake and emergency intervention mechanism for the delivery of protective services. As such, PSU did not experience major problems in case transference and unrealistic caseloads.[5]

[5]We are not suggesting that the fact of being a federally funded project was the only and/or the major reason for the problem CES experienced in case transference. We would suggest that program sanction from top administrative personnel would have ameliorated the situation considerably.

While PSU lacked the components with which CES was endowed to intervene in crisis situations, this very lack, particularly emergency foster care, can be viewed, in part at least, as a reason PSU experienced no unusual major problems in the intervention process. Certainly, problems of definition plagued PSU workers as CES workers and, undoubtedly, PSU workers felt the sting for inappropriate case actions, e.g., not removing children who were subsequently seriously harmed or removing children over parent's objection and perhaps later supported by court ruling of abuse unsubstantiated. However, not having the emergency foster care components at its immediate disposal to bring to bear upon crisis situations, the PSU was probably less inclined toward emergency removal and thus encountered fewer problems from enraged parents.

The major problems in the PSU operations, as we observed them, were related to the delivery of services. Problems of this nature are discussed below.

Lack of 24-hour, 7 day week intake. -- In order that a system can provide the services it is designed to provide, there must be a mechanism for getting consumers into the system. The PSU intake is DHR's mechanism for getting children into the protective service delivery system. In order that a system can provide services when they are needed, intake must be available at all times, especially during periods identified as periods of the greatest need. In protective service, these periods have been identified as late evening, early morning, and on weekends. It was in this latter service provision need that the PSU was found to be wanting. Intake at DHR's Protective Service Unit was provided only during the agency's office hours, i.e., 8:00 a.m. - 5:00 p.m. Monday through Friday.

Intake workers at the police department received calls and acted on complaints after DHR's office hours. And, in no way, was there a planned, coordinated procedure for interagency case handling. We shall return to this point later in this chapter.

In many such cases, the orderly sequence of services, which the PSU was normally able to provide, was not possible. For example, case assessment by the PSU might well occur after parents were jailed and children were unnecessarily and inappropriately removed from the home. Indeed, we recall that line officers expressed a punitive stance toward handling parents and a protective approach involving the removal of children from the home for most situations they might have encountered.

Beyond the harm which could have been bestowed upon the situation, i.e., inappropriate and/or lack of services to children and parents, intake by law enforcement personnel hindered identification of and subsequent services to children in need by PSU workers. It was indicated earlier and supported by law enforcement personnel and PSU workers that police officers failed to report cases to the PSU. Further, workers in both systems acknowledge the absence of uniform interagency procedures for case referral and handling.

Lack of coordination between systems. -- Lack of coordination between collateral systems for CES and PSU will be treated in more detail in a following chapter. At this point, a discussion only of the major system having direct impact on the operations of the PSU will be considered, i.e., law enforcement.

It is a fact that 24-hour intake is not provided through DHR's Protective Service Unit. Consequently, certain problems have been experienced in the delivery of services by the PSU. But, in thinking more closely on the problem and from a community perspective, one might consider that it is not 24-hour coverage which is lacking and thus problematic in the community's system for the protection of children; rather, a lack of coordination of the major systems with respect to coverage from intake through resolution. For indeed, law enforcement takes over where the PSU leaves off. There simply has not existed procedures for tying the ends together.

Any problem which could be discussed as a consequence of the lack of 24-hour intake could probably apply as a problem related to lack of coordination between law enforcement and the PSU. Thus, rather than repeating problems or developing them more fully, I would like simply to suggest that a remedy to this coordination issue would go a long ways in resolving after office hours intake problems. Optimistically, this might not be too difficult to accomplish; workers from both systems expressed needs for uniformity in procedures, conjoint investigatory efforts, and a closer clearly defined relationship.

Lack of available services. -- One of the major differences between CES and PSU existed in the availability of services which could be brought to bear in crisis situ-

ations. Protective Service Unit workers were limited in the alternatives they could call upon without bureaucratic red tape. For example, in situations which could be considered dangerous to children but which would be resolved without removal if an outside force could be placed in the home to aid in the stabilizing process, PSU workers only had the option of removing or allowing the children to remain in the situation. And, of course, they could hope and/or pray. There were DHR homemakers, however, but they were not available to PSU workers on a "moment's notice." Requests had to be made; eligibility had to be shown; and so on, more red tape. In fact, homemakers were not available to protective workers at all unless clients were AFDC recipients.

As another example, emergency foster homes were a part of DHR's resources. But again, these resources were not intricately tied to the PSU such that immediate availability could be assured. Further, there was a virtual absence of homes for children with specialized needs.

Summary Statement

The Protective Service Unit of the Savannah, Chatham County Department of Human Resources, appeared to have been hampered more in its conversions (operations) processes by operations of external systems than by a lack of internal coordination and cooperation. Seemingly, if careful thought and planning could be given to the tying of existing DHR resources to the Unit, the PSU could easily become a functioning comprehensive emergency service system.

Chapter 6

COMPARATIVE SUMMARY OF SERVICE FLOW

We have dsecribed the operations of two service delivery systems for the protection of abused and neglected children, one being in Nashville, Davidson County, Tennessee and the other in Savannah, Chatham County, Georgia, and the relationship of the systems to community collateral systems. Both systems had particular strengths, but neither had all of the strengths that might be desirable in a community system of services for the protection of abused and neglected children. If the goal in a community, through various service systems, is the provision of protection to *all* abused and neglected children, then neither community network was successful in accomplishing this goal. In both communities, however, the public agency having the major responsibility for the delivery of protective services realized relative success in handling incidents coming to their attention, i.e., investigating complaints with some immediacy and the offering of services.[1]

Having made the above general observation, the remainder of this chapter will focus on:

1. similarities and differences between the two systems in terms of system structure,
2. a comparative evaluation of the systems' functions,
3. a summary of major insights, and
4. a presentation of recommendations.

System Structure

While we have discussed the systems' operations, i.e., organizational behaviors, it is at this point that a detailed discussion of the systems' design and structure appears most strategic.

Although both systems were, in fact, a subsystem of larger systems, namely the local public welfare agency directly, and both the state public welfare and political systems at a more removed level, CES in Nashville – barring the constraints posed by OCD and the State systems – operated to a large extent as a separable and self contained system apart from the parent agency. This characteristic was not one of initial design or intention.

The system was conceived as an emergency unit – crisis intervention – designed to render short-term "stabilizing" services after which most cases could be safely transferred to regular protective services or some other unit of the County Department of Public Welfare. Noting, the CES diagram in Figure 1, the emergency service unit (CES) should have terminated its case involvement at points C, D, or E. In reality, this did not occur. In cases in which children entered the court system via D or E, CES personnel remained responsible for case handling. Intake workers were responsible for children and their families when temporary foster care was the order of the court and for families when children were placed in group homes or treatment institutions. Thus, CES as a crisis intervention unit, was involved in some cases up to and conceivably longer than twelve (12) months.

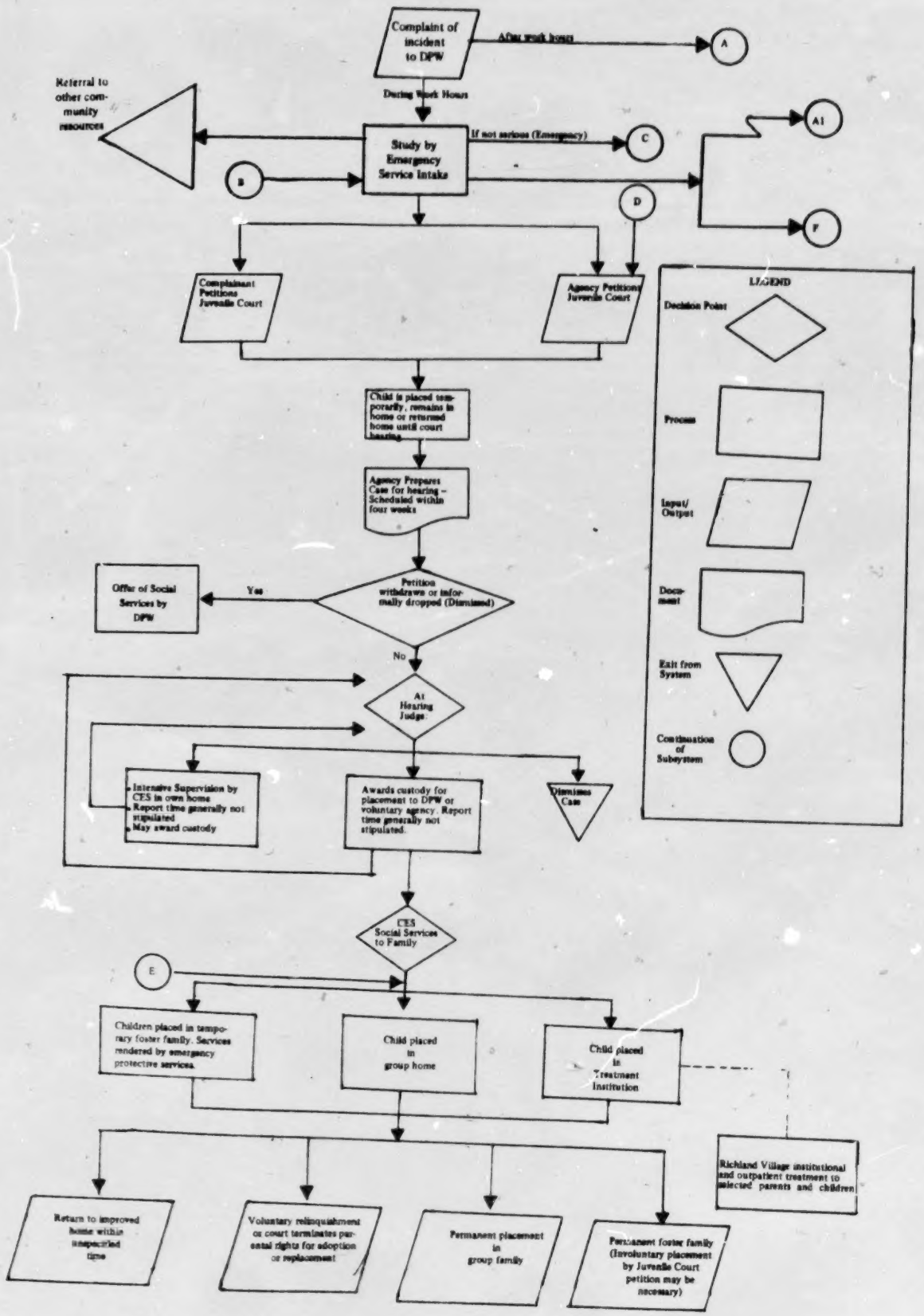
Like any project, CES went through several modifications in staff positions, but the structure basically remained the same throughout its existence as a federally funded demonstration project. Toward the end of the project's funding as a federally funded program, CES was comprised of the following staff:

- Five Emergency Service Intake Workers
- One Supervisor of the Emergency Service Unit (at times this supervisory function was the responsibility of the Project Director)
- Ten Emergency Homemakers (at an earlier stage of the project, there were four)
- One Supervisor of Emergency Homemakers
- Two Welfare Workers II (responsible for recruitment and supervision of emergency homes in the foster homes component of the

[1] This notation on success is made in reference to the operations through which services were provided. We are not herein referring to the specifics of services offered nor to the impact thereof. These issues will be addressed in a forthcoming monograph. The immediacy of response to complaints and program service capability were a more positive factor in Nashville than in Savannah.

Figure 1

CES SYSTEM


Complaint of incident to DPW
After work hours
A
During Work Hours
Referral to other community resources
Study by Emergency Service Intake
If not serious (Emergency)
C
B
D
A1
F
Complainant Petitions Juvenile Court
Agency Petitions Juvenile Court
Child is placed temporarily, remains in home or returned home until court hearing
Agency Prepares Case for hearing – Scheduled within four weeks
Offer of Social Services by DFW
Yes
Petition withdrawn or informally dropped (Dismissed)
No
At Hearing Judge
Intensive Supervision by CES in own home
Report time generally not stipulated
May award custody
Awards custody for placement to DFW or voluntary agency. Report time generally not stipulated.
Dismisses Case
CES Social Services to Family
E
Children placed in temporary foster family. Services rendered by emergency protective services.
Child placed in group home
Child placed in Treatment Institution
Richland Village institutional and outpatient treatment to selected parents and children
Return to improved home within unspecified time
Voluntary relinquishment or court terminates parental rights for adoption or replacement
Permanent placement in group family
Permanent foster family (Involuntary placement by Juvenile Court petition may be necessary)
LEGEND
Decision Point
Process
Input/ Output
Document
Exit from System
Continuation of Subsystem

CES SYSTEM (Continued)

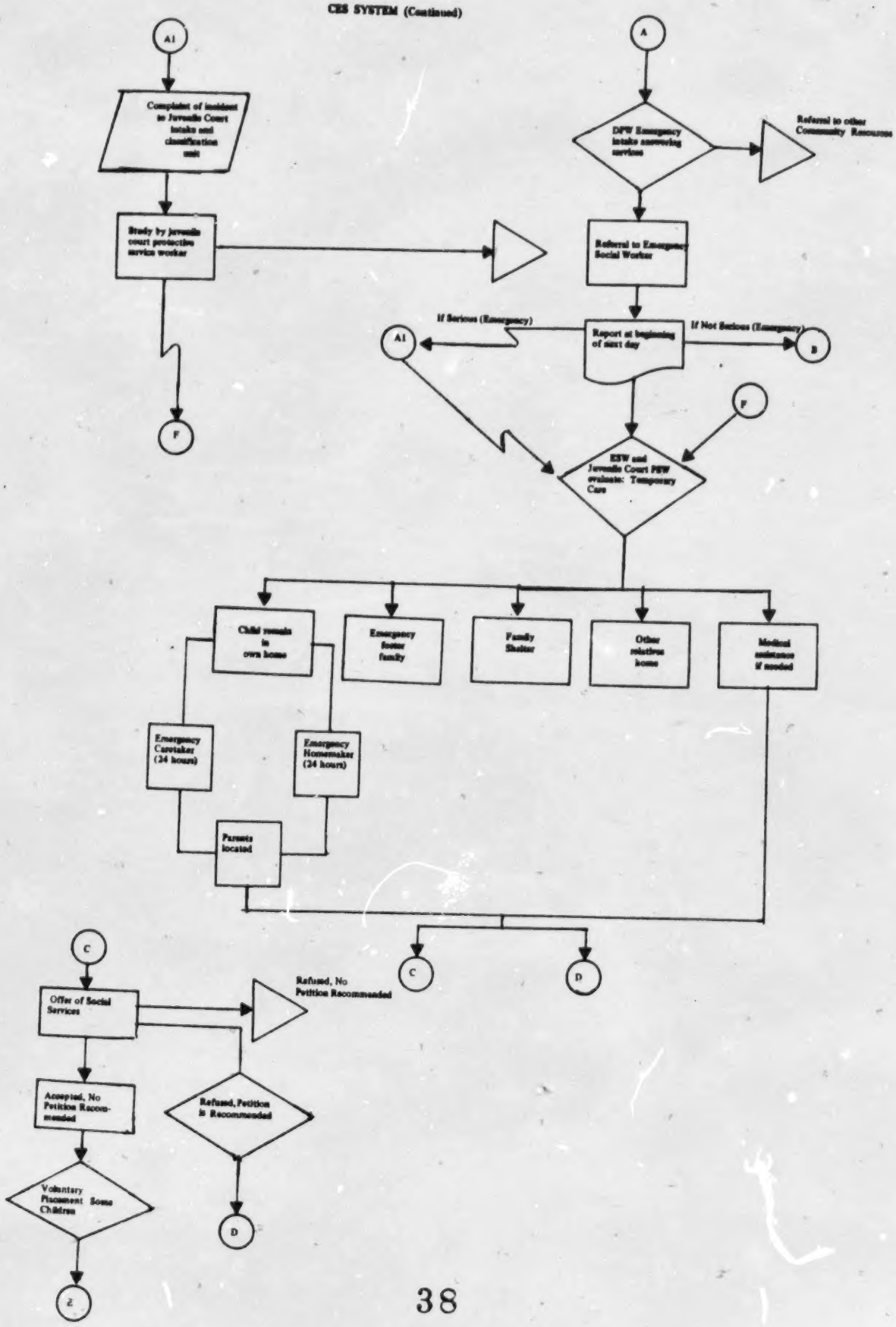


Figure 2

PSU SYSTEM

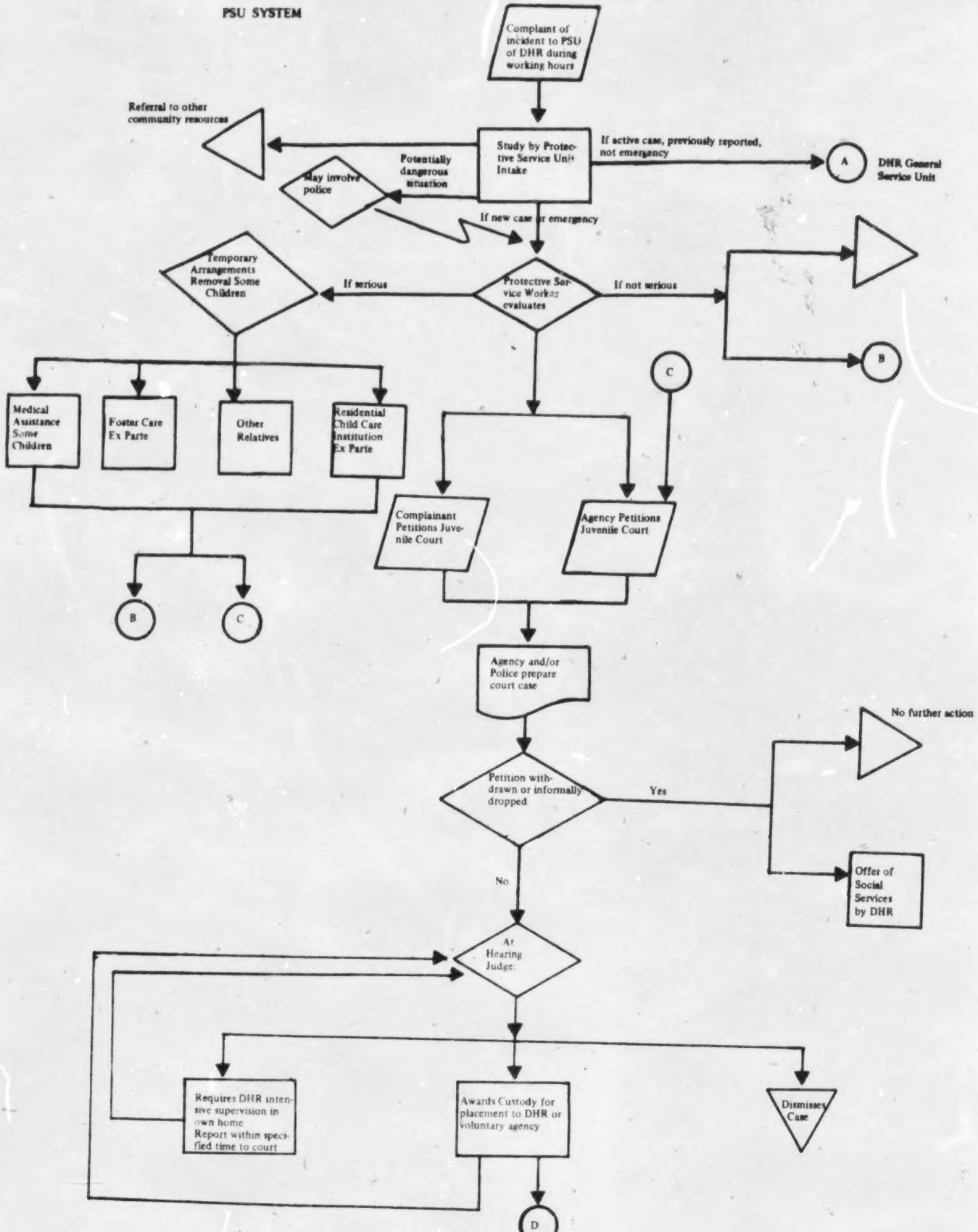
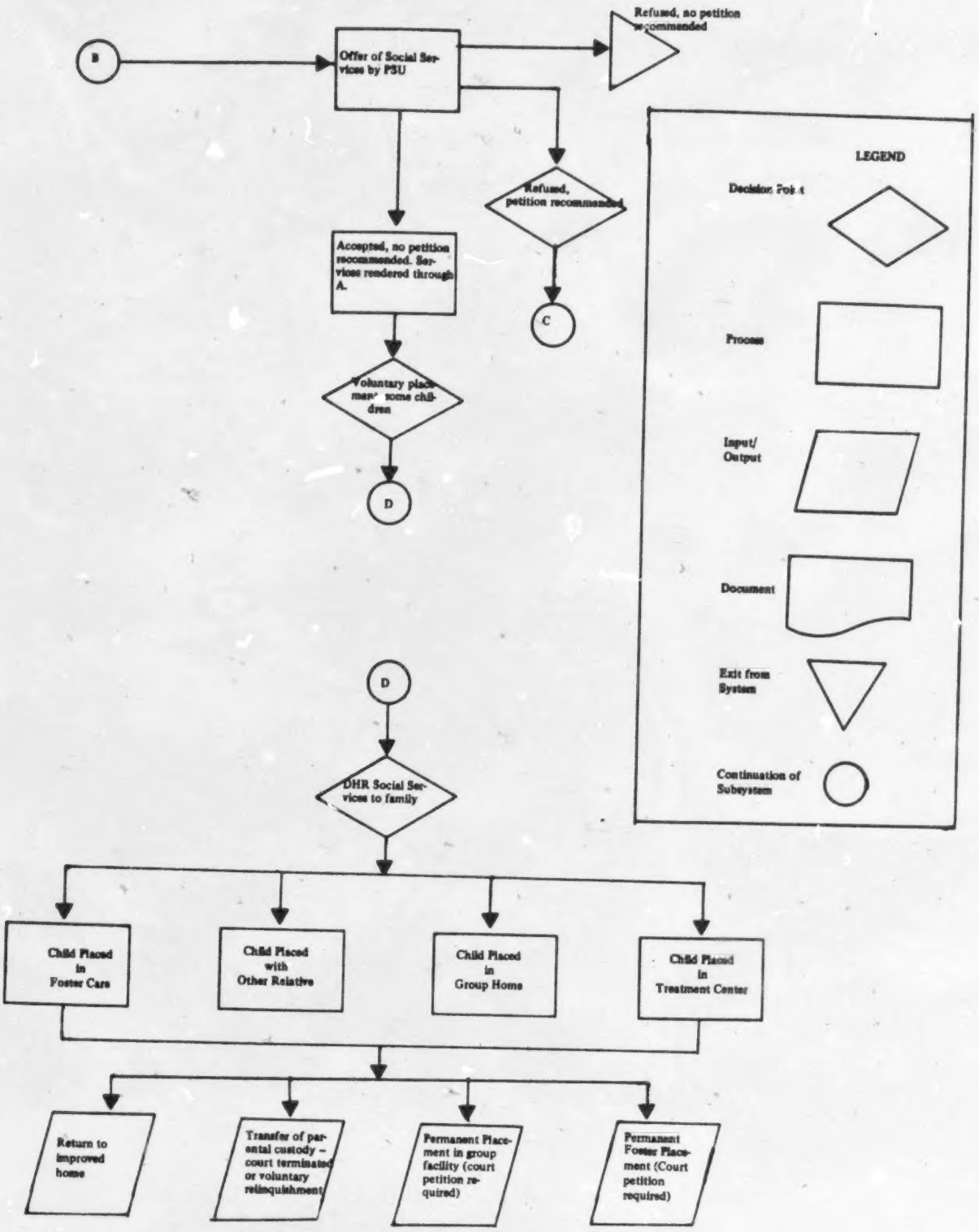

Complaint of incident to PSU of DHR during working hours
Study by Protective Service Unit Intake
Referral to other community resources
Potentially dangerous situation
May involve police
If active case, previously reported, not emergency
A
DHR General Service Unit
If new case or emergency
Temporary Arrangements Removal Some Children
If serious
Protective Service Worker evaluates
If not serious
B
C
Medical Assistance Some Children
Foster Care Ex Parte
Other Relatives
Residential Child Care Institution Ex Parte
Complainant Petitions Juvenile Court
Agency Petitions Juvenile Court
B
C
Agency and/or Police prepare court case
No further action
Petition withdrawn or informally dropped
Yes
No
Offer of Social Services by DHR
At Hearing Judge:
Requires DHR intensive supervision in own home Report within specified time to court
Awards Custody for placement to DHR or voluntary agency
Dismisses Case
D

Figure 2

PSU SYSTEM (Continued)



program -- previously there were three such workers).

At the time of the study period, there were six community based emergency foster homes. At one period in the project there were eight such homes.

The structure and staff of CES was tied to the parent agency basically through the interrelations of supervisors. While case transferral, i.e., from the emergency unit (CES) to regular units in the parent agency was not without its problems, transferrals in general involved consultation between the two units' supervisors.

Unlike CES in Nashville, the PSU in Savannah was structurally and operationally an integral part of the parent system. PSU was designed as a separate unit to provide crisis intervention in situations so defined by the protective service intake worker. Noting Figure 2, the PSU normally terminated its actual case involvement at points A, B, or C. Beyond point C, PSU was available to workers for consultation and technical advice.

At the time of the study the Protective Service Unit was comprised of six workers, one being a supervisor of protective services. The point at which intake workers terminated their involvement in cases signaled the beginning or continuing involvement of another unit within the agency. The smooth operations between the PSU and other agency units was undoubtedly one of the major reasons PSU workers were not responsible for an active on-going caseload.

Like any other project, CES as a model for the coordination of services to abused, neglected, and children otherwise in need of services, possessed several strengths and weaknesses. *Its major strengths were in its structure, i.e., service components intricately tied to the emergency unit. This characteristic allowed for immediate response to situations and the offering of ameliorative services without the disadvantages of bureaucratic red tape.* This strength of CES was a weakness in the Savannah PSU. One of the major weaknesses of CES also emanated from its very "operating" structure. The product flow between CES as the emergency unit and other units in the County Department of Public Welfare was haphazard, time-consuming, and was marked by ill-defined inter-unit authorities, expectations, and procedures. Conversely, the product flow between PSU and other agency units was a major strength in the Savannah system.

Comparative Evaluation of the Systems' Functions

1. Coordinating and cooperating with the environment

- Compliance as Criterion: Incidence Coverage

The extent to which the mandated protective service system can accomplish comprehensive coverage of the population in need, i.e., abused and neglected children and their families, is determined, in part, by the extent to which identified incidents are reported to the system. Collateral systems, especially health/medical facilities, law enforcement agencies, and the juvenile court are a major potential input source. However, the extent to which these systems actually report identified cases to the protective service system depends, in large measure, on the level of interagency coordination and cooperation initiated and/or maintained by the protective service system. Thus, the extent of incidence coverage is viewed as a measure of the extent to which the protective service system fulfills the function of obtaining and maintaining coordinated and cooperative relationships with the environment.

In one sense the evolution of the CES project provides an excellent example of community planning for meeting an identified problem "head-on." In 1968-69 the local government, recognizing the increasing number of children entering the Juvenile Court on neglect/dependent petitions and the attending problem of the rising need for additional shelter care, initiated community action toward the end of a better understanding of the problem and working on alternative solutions to the problem. The CES Coordinating Committee, which was brought together initially by members of the Mayor's Office, included representatives from the major medical, educational, law enforcement and social service systems. While the Coordinating Committee was charged with the task of working on alternative solutions to the problem, the local DPW was responsible for designing the CES system and developing a proposal for Federal funding. The project was funded for a period of three years, beginning July, 1971, and ending June, 1974.

At the time of the study there were no identified concerted community efforts toward the coordination of protective services in Savannah.

Given the different levels of community involvement, the question then becomes one of how the two

protective service systems differed in the fulfillment of the function of obtaining and maintaining coordinated and cooperative relationships with the environment.

Health/Medical Systems

It was determined that in both communities, health/medical facilities were a major source for the detection of abused and neglected children. Eight of ten hospitals in Nashville and all four hospitals in Savannah indicated an increase in abuse and neglect cases. Two private hospitals in Nashville indicated that such an increase had not occurred.

While it was generally reported that child abuse and neglect were increasingly a problem facing health/medical facilities, hospitals and other such systems were responsible for limited input into the mandated protective service system in both sites studied. This point was corroborated by protective service workers in both sites.

It appears from the findings that neither system was a success in obtaining and maintaining a coordinated and cooperative relationship with health/medical systems.

From the perspective of protective service workers in both sites, the failure of hospitals to report was indicative of a lack of cooperation with the recognized protective service system in its goal of child protection. Information gathered from medical facilities; however, suggests that the lack of knowledge and coordination, rather than a lack of cooperation, was a more contributing factor to the general failure to report identified cases of abuse and neglect.

In Nashville, seven of the ten hospitals indicated a need for standardized procedures for handling abuse and neglect cases. This was a concern of all the interviewees in Savannah. Beyond this, health/medical facilities in both sites needed more information on the "protective service" system's philosophy and the defined procedures for case handling, e.g., who should be called.

In addition to improved interagency coordination, health/medical facilities lacked coordination in their own internal operations. It was noted in both sites that intra-system handling of child abuse and neglect cases in the medical facilities was hampered by a lack of knowledge or education, a lack of coordinated efforts among key personnel, and a lack of training for case handling.

It appears from the findings that neither system was a success in obtaining and maintaining a coordinated and cooperative relationship with health/medical systems.

Law Enforcement

Law enforcement officers are in a strategic position to detect and channel abused and neglected children into the formal protective service system. In Savannah and to a lesser degree in Nashville, it was determined that officers took the hard line (removal of children-punishment of parent) approach rather than the "therapeutic" approach via the public protective service system. Several possible factors were revealed in the present study, e.g., criminal sanctions in the law which may prevent officers from assuming a helping attitude toward those who abuse and/or neglect children, lack of education and training for law enforcement personnel, and lack of intra and inter-system coordination.

Because police department personnel were included in the planning prior to the implementation of CES in Nashville, one could surmise that a lack of cooperation rather than a lack of coordination contributed to initial interagency case handling problems.

But to what could the lack of cooperation be attributed in view of the apparent community interest in the problems of child abuse and neglect by launching the new demonstration project? One could suggest that the prescription in the law, i.e., child abuse is a misdemeanor carrying a fine of not more than one thousand dollars or imprisonment of not more than eleven months and twenty-nine days or both, would dictate that police officers assume a punitive rather than a rehabilitative approach.

Similarly in Savannah, interagency case handling problems existed with line officers taking a punitive approach. In this instance, a lack of intra and inter-system coordination rather than a lack of cooperation were apparent factors. Both law enforcement personnel and protective service workers indicated that a cooperative relationship existed when there was a need for interagency cooperation. However, from a procedural standpoint, there were confusions and ambiguities on when and how to get cases from the law enforcement system to that of protective services. Further, while officers indicated actions, e.g., pick up child, remove, etc., revealing punitive attitudes, the reality of the situation prevented a more

desirable approach even if attitudes were different.

In Savannah, law enforcers received complaints of child abuse and neglect after DHR's work day and on weekends. This situation which was not coordinated with PSU's efforts and activities, coupled with a virtual lack of emergency resources, necessitated the characteristic actions of line officers.

A further factor revealed in our interviewing in Savannah provided additional insight into the law enforcement--protective service relationship. Unlike the line officers, whose most common expressed reaction to most situations involving abuse and neglect was punitive in nature, the chief administrator indicated that all cases would be referred to DHR for handling except those reported after DHR's work hours and those having serious consequences for children. This suggests that the top administrator in the police department expressed a philosophical stance not too far removed from that of PSU.

On the other hand, the administrator and direct line officers were miles apart. One possible reason for this is the usual tendency for interagency communication, if it exists at all, to occur at the supervisory level. As one officer pointed out, "We don't really communicate policeman to caseworker; what communication there is, is always between their supervisors and our supervisors."

While evidence pointed to the lack of interagency coordination in Savannah, e.g., the lack of defined procedures, the failures in the flow of information from the supervisory level down through the ranks, this kind of situation could have contributed to the initial problems in the CES-law enforcement relationship in Nashville as well. This is to say that representation of law enforcement personnel in the preplanning stages for CES did occur but perhaps was not sufficient to elicit the kind of actions desired of police officers by CES personnel. The actions of law enforcers which initially – and currently to a lesser degree – caused problems for CES in case handling did not suggest to me, at least, that the goals of the CES program, the underlying philosophy of protective services, and any knowledge and/or training techniques gathered by law enforcement personnel in the planning sessions were communicated down to those officers who were directly responsive to abuse and neglect situations.

Juvenile Court

Historically, the dual purpose of the juvenile court has been that of adjudication and making dispositions on child oriented cases which enter its arena and to exericse its powers to provide, through community systems, for the care, custody, and discipline of children should they become wards of the state. As such, the juvenile court has been a "distribution center" for neglected and dependent children rather than a "service" component of the protective service system. Following dispositional decisions of the court, actual services to children have traditionally been rendered by public and private social welfare agencies.

In lieu of innovative approaches to child protection, the juvenile court yet remains a major source for input into the community formal protective service agency. One problem in the process may be viewed as a function of the point at which input into the protective service system takes place.

Barring any just and/or unjust charges against the social service delivery systems, it is generally assumed that the sooner the protective service agency becomes involved in cases at the point of intake and/or prior to major decisions, e.g., petition, removal, etc., the less likely children will be unnecessarily exposed to the "ills" associated with court proceedings.

In Nashville, juvenile court input into the CES system occurred at the point of intake. Non-serious cases were referred to CES for case investigation and handling. In each case defined as an emergency, the protective service worker from the Juvenile Court and a CES worker made a joint field investigation. The field assessment reportedly resulted in joint decisions regarding the emergency needs of children and their families.

In Savannah, the juvenile court input into the PSU was haphazard and ill defined. While PSU was viewed as the proper agency for serving neglected and abused children, there were no mechanisms operating which provided for immediate input into PSU. This was especially true in situations occurring after DHR's work day hours and on weekends. Further, juvenile court workers were not able to make investigations in the field. The expression of these workers for more involvement with DHR in

abuse and neglect cases, in conjunction with the apparent success in the modified role of juvenile court workers in the CES system, appear to stand as strong support for a closer look at possibilities for future relationships between PSU and the Juvenile Court in Savannah.

2. Intake

- Expediency as a criterion

The intake function is but one of the several activities in the response process on which the determination of expediency has been based. However, the extent to which the intake process is expedient is to that degree a determinant of the expediency of the total response process.

When intake into a service delivery system is restricted to work day hours, one can assume that response by the system would be less expedient than when intake is available on a twenty-four hour basis.

In Nashville's CES system, intake was available on a twenty-four hour basis. During work hours, complaints were received by the emergency intake workers. After work hours in the CES system, complaints were received through the DPW emergency intake answering service which, upon preliminary screening, referred cases needing immediate assessment to the emergency intake worker "on call."

By contrast, intake into the PSU in Savannah was limited to the work day (8:00 a.m. through 5:00 p.m.) five days a week. Complaints were handled by law enforcers after work day hours and on weekends. The efforts of the two "intake channels" were not coordinated. Needless to say, cases handled after PSU's work day hours and on weekends would either not be channeled to PSU intake or would take a longer period of time between complaint and PSU involvement than if intake were provided on a twenty-four hour basis through PSU.

- Efficiency as a criterion

Efficiency in the intake process has implications for subsequent case handling. It was determined in Nashville and in Savannah that where intake activities of the several systems were not coordinated, the total response process was hampered. Succinctly, inappropriate handling of cases by other systems poses more problems for the delivery of services by the protective service system, i.e., impedes the orderly sequencing of services, making their delivery difficult or impossible.

In the CES system, the intake function was a coordinated and cooperative venture with Juvenile Court intake. Each case defined as serious or an emergency at CES intake was reported to the Juvenile Court intake. Reportedly, all calls received at Juvenile Court intake were reported to CES. Each case defined as an emergency was assessed immediately by the CES worker and the protective service worker from the Juvenile Court.

The relationship between CES and police officers reportedly improved significantly over the life of the project. According to CES personnel, with the passage of time, all except extreme cases received by police officers were reported to CES or the Juvenile Court before police action was taken.

In Savannah, there was virtually no coordination between the intake channel in the several systems. Accordingly, case handling procedures by other "intake" systems often made the delivery of services by PSU problematic.

- Compliance as a criterion: incidence coverage

Limited and/or delayed input from "intake" systems is a major concern of protective service systems from the standpoint of their failure to provide more comprehensive coverage of the population at risk or to provide services in an orderly sequence.

In Nashville, input into the CES system via Juvenile Court intake, reportedly, represented comprehensive coverage. Early in the life of the project a sizeable percentage of complaints, received at the police department intake or otherwise handled by law enforcers, were not reported to CES prior to police actions. CES personnel indicated, however, that the process had become more uniform and provided a move toward comprehensive coverage by CES of children coming to the attention of law enforcement personnel.

In Savannah, input into the protective service system via the Juvenile Court and the police department was both limited and delayed. This situation was aptly expressed by a PSU worker who remarked that "Police don't always report to us; they don't refer when they

should."

- Operational definition of abuse as a criterion

One determinant of the actions to be taken at the point of intake; namely, referral, no action, and immediate versus delayed response, would appear to be that of definition. The extent to which conditions and/or situations appropriate to the service of the system are both defined and prioritized partially determines the response set of the intake function. Clear definitions should enhance the intake process.

While the activities in the intake process necessarily involved a degree of subjective judgment on the part of CES emergency intake workers, the intake function was guided by written policy defining relevant conditions and setting priorities for response actions. By contrast, workers in the PSU in Savannah reportedly operated primarily on the basis of personal criteria. It became apparent from the interviews that the procedural manual for caseworkers was too general and of little value by way of definition.

3. Screening

- Operational definition of abuse as a criterion

As screening is a legitimate activity of the intake process, any advantages of an operational definition and policy regarding priorities of services to the intake process can also be viewed as advantages in screening.

Through screening in the Nashville CES system a determination was made on: (1) the appropriateness of complaints as defined by policy, (2) the actions as determined by intra and interagency procedures, and (3) the expediency of response according to specified priority.

By contrast, screening in the PSU system resulted in a determination of the above without the advantage of clear definitions and set priorities. In addition to the above, assignments for investigatory purposes and case assignments resulted from the screening activities. We shall explicate this point in the discussions of investigation and case assignment.

4. Investigation

- Expediency as a criterion

A partial analysis of Level II data clearly indicates that CES responded to complaints more promptly than did PSU. Analyzing two decks of case data -- Deck 1 being serial abuse cases (N=86), and Deck 2 being isolated incident cases (N=103) - we found that CES generally investigated Deck 1 cases more quickly than Deck 2 cases. Investigation was initiated in less than twenty-four hours from the receipt of the complaint in 80.2 percent of Deck 1 cases and in 78.6 percent of Deck 2 cases. This compares to 69.4 percent of Deck 1 (N=49) and 64.7 percent of Deck 2 (N=173) investigated by PSU in Savannah in less than twenty-four hours.

Noting Deck 1 cases only, CES investigated 86.3 percent of the serious cases and 77.2 percent of the non-serious cases in less than twenty-four hours. By comparison, PSU investigated 73.3 percent of the serious and 67.6 percent of the non-serious within that time period.

- Compliance as a criterion: investigatory coverage

Reportedly, CES investigated all complaints which could not be referred to other community resources or otherwise deflected from CES. On the other hand, PSU indicated that most abuse complaints were investigated; while a relatively large percent of neglect complaints was not.

- Efficiency as a criterion

CES was responsible for investigating all complaints which could not be deflected from CES. Investigative work on non-serious/non-emergency situations was conducted by the emergency intake worker. Each case defined as serious or an emergency by CES or the Juvenile Court intake was assessed in the field by a CES emergency intake worker and a protective service worker from the Juvenile Court. Conditions of neglect, not falling within the types of conditions defined as relevant to CES services, were routed to the regular DPW protective service unit for investigation.

The coordinated approach to intake and investigation undoubtedly contributed to the expediency with which investigations were initiated and to the potential for comprehensive coverage of complaints received.

As indicated earlier, the responsibility for investigating was determined through the screening process in the PSU. Complaints on active or previously referred cases and/or were not of an emergency or serious nature were referred to some other unit in the parent agency for investigation.

Investigation by PSU was conducted only if the

complaint involved a new case and/or if the situation were defined as serious or as an emergency. In no instance was there an interagency coordinated approach to investigation.

One point bears emphasis in comparing the two systems on the investigatory function. CES had more efficient operations in relation to conjoint efforts with the Juvenile Court in emergency situations. On the other hand, it appears that in terms of internal operations with respect to the investigative function the PSU system was more efficient.

We are suggesting that when a volumn of cases can be deflected from the protective service system intake for investigative purposes, more time and manpower will be available for situations requiring immediate intervention.

Thus, what seems to be indicated is that there are tradeoffs in policy decisions. While operating definitions and set priorities for investigation were undoubtedly advantageous to CES personnel; namely, clarifying relevant situations, they were perhaps at the same time dysfunctional. Policy on definition and priorities prescribed what kinds of situations "had" to be investigated by the system where, in fact, screening might have suggested some cases falling within the types could have safely been assigned to the regular protective service unit for investigative purposes. More specifically, a "have to" situation would almost demand a random rather than a discriminating response pattern.

While there was indeed an overall pattern to intervention by both systems in that expediency tended to reflect response based on severity and knowledge of case, a closer look at the data reveals problems in CES intervention pattern.

For the sake of explication, the following Level II, combined Decks 1 and 2, data are presented with prefacing remarks: (1) the caseload handled by the systems differed with respect to severity -- a little over twenty-four percent in Savannah and a little less than forty percent of the cases in Nashville were determined to be serious in nature; (2) with the majority of the cases being accounted for in the less than twenty-four hour time period, percentages in the remaining time periods are necessarily based on small numbers. However, the distribution of the percentages gives credence to the following discus-

Time Between Reported Incident and Investigation: Decks 1 and 2

Time	Savannah-PSU						Nashville-CES					
	Severity						Severity					
	Not Serious		Serious		Total		Not Serious		Serious		Total	
< 24 hours	102	69.9 (62.6)	44	30.1 (74.6)	146	65.8	91	60.7 (78.4)	59	39.3 (80.8)	150	79.4
1 day < 2	18	81.8 (11.0)	4	18.2 (06.8)	22	9.9	10	62.5 (08.6)	6	37.5 (08.2)	16	8.5
2 days < 1 week	15	71.4 (09.2)	6	28.6 (10.2)	21	9.5	8	66.7 (06.9)	4	33.3 (05.5)	12	6.3
1 week < 1 month	17	89.5 (10.4)	2	10.5 (03.4)	19	8.6	7	70.0 (06.0)	3	30.0 (04.1)	10	5.3
1 month or more	11	78.6 (06.7)	3	21.4 (05.1)	14	6.3	0	-----	1	100.0 (01.4)	1	.5
Total	163	73.4	59	26.6	222	100.0	116	61.4	73	38.6	189	100.0

sion.[2]

The data leave little room for doubting the capacity in the Nashville system for more expediency in responding to complaints than that in the Savannah system. However, a close look at the tabular data indicates that while approximately eighty percent of all cases were responded to in Nashville in less than twenty-four hours as compared to less than two-thirds in the same time period in Savannah, the response pattern in relation to severity appeared to be less discriminating in Nashville than that in Savannah.

If a response pattern is discrimatory rather than random, one would expect that the percent of serious cases in proportion to non-serious cases would decrease with the advancement of time. While there are irregularities in the Savannah data – most noticeably for the period two days to less than one week – the general expected pattern is observed. On the other hand, Nashville's data revealed that while there was a decreasing pattern, the percent of serious cases in relation to non-serious cases changed minimally over the several time periods.

The following question is posed. To what degree could CES personnel actually set priorities to investigation when, in fact, they were responsible for investigating practically all situations? Obviously, time spent on non-serious complaints detracted from the time available for situations warranting immediate intervention.

5. Case Assignment

- Efficiency as a criterion

Case assignment for on-going services in both systems appeared to be based to a large extent on structural and organizational aspects of the systems.

All cases opened by CES intake were assigned to and carried by CES emergency intake workers. While intake and investigative work on non-serious/non-emergency situations was conducted by emergency intake workers, these cases, if transferrable, were carried by workers in the regular protective service or some other unit of DPW. Reportedly, there was no clear policy on what kinds of cases were accepted by the parent agency.

Poor relationships between the CES project and the parent agency were evident. CES was in no position to "force" cases on other units in the larger system if the units refused to accept them. As a result of this organizational constraint; namely, the inability to transfer cases when needed; each emergency intake worker carried an average caseload of forty cases.

On the other hand, case assignment in the PSU followed the screening process at intake. Some cases received at intake were investigated by workers in other units of DHR. These categories of cases, unless further assessment revealed a need for "crisis" handling, were assigned to units other than the PSU. Cases involving active clients on whom reports were received were assigned to the regular caseworker for investigation and on-going case handling.

Beyond intake and handling the identified emergency or resolving the immediate crisis, PSU workers were not responsible for case handling. Cases were transferred to some other unit of DHR. In addition to this initial case responsibility, PSU workers consulted with and advised workers assigned to cases in which court action was necessary.

6. Case Handling

- Efficiency as a criterion

An intervention system having access to provisions for long-term services would need to define and limit its delivery of services to short-term stabilizing efforts. Case handling needs to be predicated on a distinction between emergency intervention and long-term services.

The virtual lack of coordination and cooperation between the CES project and the parent system in the case transferral process demanded that CES emergency intake workers were responsible for the delivery of long-term as well as short-term interventive services.

By contrast, PSU case handling function was limited

[2] We are not able to explain the difference in severity in the two systems' caseload. Perhaps, there are a number of factors which account for the difference, among which are: (1) difference in level of problem awareness, (2) the movement toward greater input of cases from hospitals in Nashville, and (3) differences between the systems' internal mechanisms for case handling.

to activities designed to ameliorate the immediate crisis. On-going services were delivered by other units of DHR. Thus, PSU personnel were not responsible for an on-going caseload.

While CES was plagued with problems in the case transferral process, CES had at its immediate disposal emergency services which could be brought to bear in handling crisis situations without bureaucratic red tape. While some of the similar kinds of services, e.g., homemakers, were available in other units of DHR, such services were not available to the PSU without formal requests, eligibility determination, and other procedural processing. Thus, the involvement of needed services in case handling was a more expedient and efficient process in the CES system.

- Operational definition of abuse as a criterion

Another apparent factor which contributed to the heavy caseloads for which CES emergency intake workers were responsible was the failure to operationally define abuse in relation to case handling. What actually existed was workers being responsible for cases falling at different points in the protection process; namely, children not placed, those placed, and those in the court process. Thus, CES as a crisis intervention system, was involved in some cases up to and conceivably longer than twelve (12) months.

By contrast, PSU defined and confined case handling function to intake and the resolution of the identified emergency or immediate crisis. Beyond these activities, PSU workers were available for consultation and advisement to workers responsible for on-going services.

A Summing Up of the Systems' Operations

Both systems were impeded in their internal operations as a result of the state of their relationship with collateral community systems. Operations were influenced negatively on two levels, one resulting from limited input from these collateral systems and the other from the ways these systems handled abuse and neglect cases.

In relation to both the CES and the PSU systems, we found that collateral systems, especially hospitals, provided limited input. Input via law enforcement and court systems in Nashville was provided on a more uniform basis than in Savannah. While limited input from collateral systems is a major concern from the standpoint of the failure to provide services to children and families in need, from a system's standpoint, the inappropriate handling of cases by other systems pose more problems for the delivery of services by the protective service system; i.e., impedes the orderly sequencing of services, making their delivery difficult or impossible.

At the time of the study, collateral systems in both communities fell short in their responsibility of channeling abused and neglected children into the protective service system. But by what mechanisms were the protective service systems able to receive those children who were channeled to their units? The 24-hour intake provision in the CES system was a major plus, while the lack of intake beyond DHR's work hours or a coordinated procedure with intake in the law enforcement or Juvenile Court system was a definite impediment to PSU's operations. Given this lack in the Savannah community network, a sudden increase in input from collateral systems would probably be less than desirable from an operational standpoint.

Related to intake capabilities are the procedures for investigating complaints. In the CES system both aspects were intricately tied to Juvenile Court operations. Conjoint coordinated approaches to investigation in emergency or crisis situations allowed for the presence of social service assessment and court authority. Seemingly, too, the coordinated intake and investigatory procedures contributed to the expediency with which investigations were initiated and to the total coverage. Reportedly all complaints which could not be referred to other community resources or otherwise deflected from CES were investigated.

This latter point is made primarily with the fact in mind that the number of intake personnel in the CES project was at the time of the study the same as the number of personnel in the PSU. Further, it bears noting that intake workers in CES were responsible for an average caseload of approximately forty cases in which children were at different stages in the protection process. On the other hand, PSU workers were not responsible for an active long-term caseload. Thus, in terms of the difference in county size (Davidson County, Tennessee–approximately 500,000 and Chatham County, Georgia–less than 200,000) and given a comparable number of key casework personnel, coordinated efforts in Davidson

County, Tennessee must be responsible in part for the differences in expediency and coverage capabilities.

As was stated earlier and at several points in this paper, a major advantage the CES system had over the PSU in Savannah was the component services which could be brought to bear upon emergency situations without the vicissitudes of bureaucratic red tape. Some of the similar kinds of services, e.g., homemakers, were available in other units of DHR. However, such services were not available to the PSU without formal requests, eligibility determination, and other procedural processing. Thus, their utility for "crisis" intervention were virtually nil.

One of the major features of an emergency or crisis intervention system is immediacy in response to complaints via investigations and ameliorative services and the successful movement of cases to other community resources or on-going units in the larger system. The operations of CES became increasingly difficult, i.e., intake workers' caseloads became increasingly larger, due, in part, to problems encountered in case transferrals. As we noted earlier, these difficulties were related both to intake workers' failure (that of CES) to operationally define crisis and to the less than desirable relationship between CES and the parent agency. The ease with which cases were transferred between PSU in Savannah and other units of DHR was a decided plus over CES operations.

In both systems, the record keeping system served as an impediment to their operations. In Nashville, the major log reflected an inflated picture of child abuse, but at the same time serial abuse was captured. In Savannah, the major log reflected a deflated picture without capturing serial abuse cases. Both systems recorded only "cold" facts on case handling; "hot" facts were imbedded within the mire of the workers' folders on the families.

In recognizing the preceding factors, it can again be stated that each system had particular strengths in operations, but neither system had all of the strengths that might be desirable in the delivery of services to children entering the service system.

Recommendations

1. There is no question that health/medical systems, law enforcement agencies, and the juvenile court are major potential sources for input into the formal protective service system. However, it is doubtful that the potential will be realized in the absence of a well coordinated and cooperative relationship between these sources and the protective service system. Thus, it is logical to assume that until coordination and cooperation with potential input sources occur, there will exist a gap between the proportion of children potentially needing services and those who are in the service delivery system.

We are suggesting that the responsibility for initiating and/or maintaining coordination and cooperation with major input sources lies with the mandated service delivery system. Who or what agency in a community network should know service eligibility, case handling procedures, and service availability better than the system responsible for the delivery of the service in question?

Far too often and for too long practitioners in the social service system have assumed that individual actors and other community agencies will or should make their wishes known by seeking out the information and/or services needed. For individuals and/or other community systems not to do so has been viewed as an indication of apathy, a lack of cooperation, or some other negative factor which places the responsibility for the failure to act on the service seeker.

Insights gained from this study suggest that a lack of coordination, knowledge, and training rather than a lack of cooperation was a more relevant explanation for limited input into the protective service system.

Where the lack of cooperation appeared to be paramount, as in the case of the relationship between CES and police officers, legal constraints existed which shaped the nature of the relationship.

In Nashville, commendable efforts through the CES Coordinating Committee were made to both obtain legitimacy and awareness for the project, and to establish needed linkages with the involved agencies and to bring about required changes in existing systems.[3]

[3]Major program changes were accomplished in Richland Village, the Salvation Army, and the Juvenile Court. See *Community Guide*, pp. 18-19.

In retrospect, the CES Coordinating Committee gained coordination and cooperation at the planning level. But beyond coordination and cooperation at the planning level is the need for coordination and cooperation at the service level.

Perhaps the initial failure of the CES project to fulfill the function of obtaining and maintaining coordination and cooperation, as reflected by limited input from the major collateral systems, can be partially explained by one or both of the following factors: (1) CES personnel initially failed to follow through at the direct service delivery level on what the Coordinating Committee accomplished at the planning level, (2) the focus of the project, in direct response to the problem which gave rise to its inception, was on deflecting children from the juvenile court system rather than on comprehensive incidence coverage.

There was a decided lack of coordination at the service delivery level in Nashville. In this respect, the situation differed little from that in Savannah. Thus, our first recommendation is that to ensure a narrowing of the gap between the proportion of children potentially needing services and those who are in the service system, *the service delivery system must initiate and/or maintain activities designed to bring about coordination and cooperation at the service level.* Education and training around problem definition and case handling procedures must be provided to direct service providers, as well as to supervisory personnel.

2. Recognizing the evident failure of the CES project to obtain and maintain coordination and cooperation with some of the major input sources, our second recommendation is that *proposals for funding intended to create permanent coordinated services in local communities include objectives, personnel, and financial outlays for the explicit purpose of providing public education, training, and coordination relevant to the goals of the service system.*[4]

3. The entrance of abused, neglected, and otherwise maltreated children into the protective service system and the orderly sequencing of services depend, in part, on the system's internal intake capabilities and the degree of cooperation and coordination between the protective service system and relevant collateral intake systems.

Unfortunately, the normal work day hours of intake workers in an eight hour-five day week arrangement do not correspond to the periods of greatest need in child

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[4]While there was some improvement in reporting from hospitals after the initial efforts made by CES; namely, providing health/medical facilities with copies of the law and copies of the standard reporting form and conducting two multidisciplined workshops, one in the latter half of 1972 and the other in April of 1973, CES recognized that the change was not a dramatic one. And while CES personnel recognized that much more should have been done, such was not the case because there was no one to do it. The survey and seminar planning which were very time-consuming were done by a graduate social work student, a former protective service worker, as a part of her field placement experience.

CES, recognizing the need for more extensive, concentrated, and organized efforts to ensure improved relations with and reporting from community collateral systems, undertook efforts to delegate this responsibility to some other community resources. CES approached the Council of Community Services with their concerns. A committee, comprised of representatives from various groups, was formed to discuss directions. The work of this committee continued until April 1974, during which time it moved in the direction of identifying the need for a position within the Department of Public Welfare with the person having primary responsibility for spearheading the community effort toward improved reporting and coordination of service delivery.

This recommendation was accompanied by an offer from the Junior League to finance, in part, the salary for the position for one year. The Department of Human Resources signed a contract with the State Executives of the Junior League for the position in December, 1975 with the position being filled during that month. The contractual arrangement between DHS and Junior League is somewhat unique.

The broad responsibilities of the coordinator will be to set up CES Statewide and to work with hospitals, law enforcement, courts, children's institutions, etc., toward improved coordination.

(From written correspondence–December 30, 1975–from Mrs. Patricia Lockett, former Director of CES Demonstration Project. She is the current Director of the National Center for Comprehensive Emergency Services to Children, Nashville, Tennessee).

protection; namely, late evening, early morning, and weekends.

Thus, a third recommendation is that *intake into the mandated protective service system must be provided on a twenty-four hour basis through an operational procedure in which the intake activities of all relevant collateral intake systems are channeled expeditiously and efficiently into the mandated protective service system.*

Embodied in this recommendation are two equally important elements: (1) the existence of a mechanism which allows for twenty-four hour availability of intake into and services through the mandated protective service system, and (2) the existence of cooperative and coordinated relations with other intake systems. The absence of either will ensure the continuance of the gap between the proportion of children potentially needing services and those who are in the service delivery system, and impediments to the orderly sequencing of services.

PSU in Savannah, Chatham County, Georgia lacked both elements. Both were present in the CES system in Nashville, Davidson County, Tennessee, with the latter existing in varying degrees among systems. Efforts are presently underway to improve coordination with all collateral systems.

Obviously, there must be a variety of ways of accomplishing both elements, among which are the methods and procedures used in the CES system. While we cannot specify methods which work best for specific types of communities, we suggest that if policy makers and planners can veer from the traditional in thinking, workable means can be developed.

Is there something sacred about the eight to five, five day week arrangement? Perhaps an arrangement utilizing shifts and workers on a rotating basis would show promise. Are not systems boundaries permeable? Some community systems, including hospitals, police departments, agencies operating "hot lines," etc., operate on a twenty-four hour basis. Interagency cooperation and coordination could possibly result in such a system providing answering service capabilities with protective service workers on call.

4. A major strength in the CES system was in its structure; namely, service components intricately tied to the system such that the offering of ameliorative services was prompt and efficient. This strength in the CES system was a major weakness in the Savannah PSU. Some of the similar kinds of services, e.g., homemakers and emergency foster homes, were available in other units of DHR. Such services, however, were not available to the PSU without formal requests, eligibility determination and other procedural processing. Thus, their utility for "crisis" intervention was virtually nil.

When the access to existing services is denied or delayed due to bureaucratic red tape, the abused, neglected, and otherwise maltreated children are further victimized. This implies that *the various service components – presently administered and guarded in separate divisions of the larger public welfare system – that affect abused and neglected children – need to be consolidated under a single service package.* Such a move need not mean the centralization of units responsible for the various services; rather, a cooperative and coordinated procedure allowing for speedier and more efficient inter-unit flow.

5. Such an approach would yet fall short of the desired, for the reality remains: different services are funded from different sources and for specific categories of consumers. Thus, while such a procedure as that suggested might improve the situation in cases where eligibility for the services is easily determined, it may not improve the situation for "borderline" cases nor for those in which the eligibility test is not met.

Since all abused, neglected, and otherwise maltreated children deserve the most appropriate service available, perhaps an alternative to the above approach would be to *marshal such services through a coalition of community groups.* The coalition could plan and conduct activities designed to recruit volunteers for specific purposes in the community's system for protecting children. Volunteers could be used in the capacity of homemakers, caretakers, emergency foster parents, etc., much on the order of schools' utilization of parents as volunteer teachers for hospitalized and home-bound children and the American Cancer Society's use of volunteers to relieve families of cancer patients. The idea is not new; the list of examples could go on.

6. One of the key areas for concern of personnel in the CES system was the problems encountered in transferring cases from the CES emergency unit to other units of the parent agency. This constraint, which was

discussed in considerable detail in Chapters 4 and 6, resulted in emergency intake workers having to carry heavy caseloads and having to plan for cases falling at different points in the child protection process. Thus, in many cases CES was directly responsible for case handling for as long as ten to twelve months. Such problems did not exist in the Savannah PSU.

It is necessary to reemphasize that the CES system was a federally funded project. This is not to suggest, however, that the fact of being funded by federal monies was the only and/or the major reason for the problematic relationship between CES and the parent agency. Certainly, there are a number of examples which indicates the eventual failure of new projects which were under the same financial umbrella as on-going programs.

The source of funding may have been a secondary factor contributing to the undesirable relationship between CES and the parent agency. The lack of positive sanction from top administrative personnel in the parent agency was perhaps a primary factor. Thus, we recommend that *where new programs are developed within a system – regardless of funding source – top administrative personnel give positive sanction to the program's operation and staff.* It is only with such continuous support that new programs can gain and maintain legitimacy and awareness within the larger system.

7. A seventh recommendation concerns the nature and extent of interagency case involvement and the implications coordinated efforts have for more efficient utilization of manpower. It was noted that the number of intake personnel in the CES system was at the time of the study the same as the number of personnel in Savannah's PSU. Intake workers in CES were responsible for long-term services in an average caseload of approximately forty cases. On the other hand, PSU workers were not directly responsible for an active long-term caseload. Beyond this, data clearly indicate that the response pattern in the CES system was more expedient than that in the PSU system. Reportedly, coverage capability was more comprehensive in the CES system.

Given the above facts and the fact of the difference in county size (Davidson County, Tennessee – approximately 500,000 and Chatham County, Georgia – less than 200,000), we suggest that perhaps the pooling of manpower resources, namely CES and Juvenile Court workers under coordinated procedural conditions contributed, in part, to the greater capacity for expedient responses to complaints and investigatory coverage in the CES system. Therefore, we recommend that *mechanisms be established between the mandated protective service system and the major collateral intake systems to ensure a more coordinated approach both to the intake and investigatory functions.*

Summary Statement

In this chapter, we have attempted to describe and compare the two protective service delivery systems on selected operational and structural aspects and on the relationships of these systems to major community collateral systems.

Efforts were made to identify salient similarities and differences, and to pinpoint factors which impeded or enhanced the systems in their operations process. It is hoped that the identification and discussion of the problem areas, as we viewed them, have produced information which can be utilized for the designing or modification of the process of assessing and serving abused and neglected children.

It is imperative that we reemphasize the focus of this report at this point. This report is based on an analysis of both systems' operations or processes. We have concerned ourselves with such issues as entrance into the system via major community collateral systems and both protective service systems' mechanisms for handling children within the systems. A subsequent report, which will be based primarily on case data, will attempt to tie input and output data to each protective service system's operations. And to the extent that the data allow, we anticipate evaluating each system's outcome or effectiveness by that method.

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